Maternal and Child Health Services
Title V Block Grant

State Narrative for Montana

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

The State of Montana maintains on file in its Fiscal Division all the assurance required by this application for Maternal an Child Health Block Grant. On file in agency rules are prohibitions of necessary items. The agency assures the MCHBG that the funds will be used for non-contruction programs, that debarment and suspension remain in place as in previous years, that the agency is a drug free work place and tobacco free. The agency has on file all necessary paperwork for lobbying state legislature and the prevention of fraudulent use of fund.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input is solicited through local public health departments in the form of pre-contract surveys. Counties are also required to include consumer surveys in their contract responsibilities, to further inform them regarding the impact of MCH programs. Administrative Rules of Montana requires counties to conduct periodic needs assessments, which are reported via the pre-contract surveys.

Public input is also obtained from the Family and Community Health Bureau (FCHB) Advisory Council members, who represent various MCH partners and constituents. Updates on the needs assessment process were provided to the FCHB AC at each meeting during the last year, and the needs assessment and the priorities were sent to the AC for review and comment prior to finalizing. Advisory Council members will be invited invited to participate in the video link to the block grant review. A report on review findings is scheduled for August, and a copy of the final reviews are sent to the AC following receipt.

Copies of the block grant are made available to Advisory Council members, and availability of the text and data and updates on the block grant are provided through the FCHB Facts newsletter. The newsletter is distributed electronically every other month, and has a distribution of approximately 180 (in department) and 100 (out of department). A copy of a recent FCHB Facts newsletter is attached.

/2007/ The public input process is unchanged from 2006. A proposal has been made that the FCHB Advisory Council members be governor-appointed (attached). A link to the MCHBG application and narrative will be added to the FCHB website. //2007//

/2008/ The public input process remained similar to 2007. The FCHB Advisory Council continued to meet quarterly in 2007 and provided input on the August 2007 MCH BG Review and on the 2008 MCHBG application. The Governor's Office has replaced the FCHB Advisory Council with the Family Health Committee and it is anticipated that the Governor's appointments will be made in the Fall of 2007. The Governor announced the Family Health Committee Members on August 15, 2007. (attached) The local county health department's lead public health officials' provided input electronically on the state's creation of a new state performance measure. The MCHBG application and narrative are available at http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml. //2008//

//2009/ The Family Health Advisory Council met every other month throughout fiscal year 2008 at which time the 2009 MCHBG application, as well as FCHB section updates and project reports, were on the agenda. Beginning with FY 09, the FHAC meeting minutes, as well as the will be MCHBG application and narrative are available at http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml.

The local city-county health departments provided input into the overall MCH BG process at the 2007 Fall Montana Public Health Association Conference and the 2008 Spring Public Health Conference.

Several FCHB Section Supervisors provided information about the MCH BG in their presentations or communications with established and new MCH partners, such as the Community School Readiness Teams, the Head Start Collaboration, and Montana's 12 Child Care Resource and Referral Agencies.

//2009//

/2010/

The Family Health Advisory Council continues to advise the Bureau regarding the MCH target populations' health needs. The Council members were appointed based on their professional interests and residence in the state which has resulted in its members hailing from a small, medium, and a large local health department; the March of Dimes; Indian Health Services; Montana Dental Association; Healthy Mothers Healthy Babies; and Planned Parenthood. At the quarterly FHAC meetings, there are regular progress updates on the Needs Assessment Process in relationship to the MCH BG application and MCH program reports. An attachment is included with this section listing the FHAC members who assisted with the creation of the Family Health Advisory Council report on Maternal and Child Health Services in the State of Montana, October 22, 2008. To view this document go to: http://www.dphhs.mt.gov/PHSD/family-health/FHACReporttoGovernorSchweitzer10_22_08.doc

In the summer of 2008, the Bureau's Graduate Student Internship Program (GSIP) assignee queried 226 professional stakeholders from across the state. They were asked to respond to an online survey asking two questions in relationship to the MCH target population: WOMEN, CHILDREN, INFANTS, CHILDREN WITH SPECIAL HEALTH CARE NEEDS, and ADOLESCENTS : "What are the five greatest health needs of (MCH target population)?" "Of these needs you identified for (MCH target population)?", which are currently unmet?" The results from the 109 respondents were shared with the FHAC, the FCHB Bureau, the local health departments, and the Public Health and Safety Division employees and will also be included in the 2010 Needs Assessment report.

The Bureau's 2009 GSIP assignee organized and facilitated a June 2009 conference call with the local health departments on the how MCH-Serving Organizations in Montana Use MCH Data. In addition to offering how they use the data, the locals were asked to submit

contact information for their MCH partners, resulting in 115 new potential partner information being collected. These potential new partners are currently completing an online survey aimed at capturing how they use or might use MCH Data. These results will also be included in the 2010 Needs Assessment report.

The Bureaus' webpage has links to a number of MCH Resources, including the 2005 Needs Assessment Report, the most recent MCH Block Grant application, and the 2008 Family Health Advisory Council Report. Go to: http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml

//2010//

An attachment is included in this section.

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

The 2005 Needs Assessment was submitted with the 2007 MCH BG application. Technical assistance specific to the state's revision of the 2005 Needs Assessment process has been requested with the 2008 application. The Needs Assessment is an ongoing process and the results continue to be included in the Family and Community Health Bureau (FCHB) Strategic Plan. The Bureau's Strategic Plan, which was based on the 5-year MCH Needs Assessment, was used by the Family and Community Health Bureau sections to develop section workplans. The workplans reflect the goals and objectives in the Bureau-wide plan, and also include activities or action steps for achieving the goals. Each section reviews and updates their work plan periodically. Additionally, the entire Bureau meets quarterly at which time the Strategic Plan is included on the agenda as a discussion item and potential updates or revisions are discussed.

/2009/
Montana is currently completing a review of the MCH BG Needs Assessment process to improve results for the 2010 submission. Following a thorough review of the 2005 Needs Assessment, a MCH Bureau Graduate Student Internship Program has been conducting a statewide preliminary planning survey to solicit feedback regarding previous methodologies, data gaps and representation. The survey goals are to gather insight from a broad spectrum of MCH stakeholders that will improve the reliability and efficiency of the upcoming MCHBG needs assessment. Among the most important components is determining if an internet based needs assessment could effectively capture the state of MCH in Montana, given the largely rural and frontier population. The preliminary planning survey will be completed in early August 2008, and a plan of action will be identified for completion of the 2010 MCHBG needs assessment. Montana staff will participate in Needs Assessment training opportunities, including the Rocky Mountain Public Health Education Consortium Training in Albuquerque in September and the planned sessions at the MCH Epidemiology Conference in Atlanta in December.

The Bureau continues to use the 2005 Needs Assessment document as the foundation for their ongoing revisions to the Blueprint for Maternal and Child Health in MT, which serves as the Bureau's strategic plan guiding each section and unit's respective work plans. The Maternal and Child Health Coordination (MCHC) Section Supervisor has taken on the role of ensuring that each of the eight priority areas includes feasible objectives based on the capacity of the responsible section, as well as ensuring that the Blueprint includes the outcomes for the previous year's objectives. Based on discussions with the individual sections, a significant number of objectives are continuing into the next fiscal year.
//2009//

/2010/ There are no changes in the population strengths and needs in the State priorities since the last Block Grant application

Since the last block grant application, the MCH epidemiology capacity within the Title V programs has expanded from one MCH epidemiologist position to an MCH epidemiology unit comprised of two MCH epidemiologists and a data coordinator. This increase in capacity allows for more data use and analysis support for all of the priorities.

The FCHB regards the needs assessment process as an ongoing, bureau-wide activity. To continue to build on the 2005 Needs Assessment, an existing Bureau team with membership from all programs in the Bureau was expanded and became the Needs

Assessment Team.

The Needs Assessment Team has developed a process for the 2010 needs assessment, building on the results and lessons learned in 2005. In the summer of 2008, an MCH Bureau Graduate Student Internship Program (GSIP) participant conducted a statewide preliminary planning survey to solicit feedback regarding previous methodologies, data gaps, and representation. This survey resulted in an initial list of priority needs and recommendations for conducting the needs assessment.

The 2010 needs assessment will include enhanced public input, greater partner involvement at the state and county level, and a systematic approach to identifying problems and possible solutions (see attached diagram of the needs assessment process.)

To achieve greater involvement of the public and partners at the state and county levels, Montana's needs assessment process will include a public input survey, focus groups with priority populations, surveys of public health professionals around the state, and interviews with key informants from the Family and Community Health Advisory Council. The input from these sources will provide an overall picture of the public and professional perspectives on MCH issues in Montana.

The public input survey will be distributed at public venues like fairs and farmer's markets to gain broad participation from around the state and to determine community priorities for MCH. The public survey will be followed up with population-specific focus groups. The focus groups were determined based on a review of data sources available for the needs assessment. Populations with the least data available to use in assessing their needs (such as adolescents and parents of CSHCN) were identified as priorities for focus groups. The focus groups will provide more in depth and specific information on their experiences with MCH issues in Montana than can be gathered from data sources.

To achieve greater involvement of partners at the state and county level, the process will include interviews with key informants from the Family and Community Health Advisory Council. Partners will also participate in "stakeholder teams" to prioritize problems.

The "problem mapping" technique will be used to identify viable approaches to addressing the priority health issues. This will help to inform the next step for the stakeholder teams -- to develop strategies to address the priority needs.

In the summer of 2009, another GSIP participant is conducting a survey to assess resources for the MCH population in the state. The survey also asks about data capacity and ways to improve data usage at the local level. The results of this survey will provide a richer picture of organizations serving the MCH population in Montana and may reveal new opportunities for partnership.

Available data sources related to maternal and child health (MCH) in Montana will be reviewed and summarized throughout the process to describe the status of MCH in Montana and inform the problem mapping and prioritization. Data will be compared to national data, regional data, or previous years of state data to assess the severity and importance of MCH issues in the state from a data perspective.

The outcome of the needs assessment will be a broad assessment of MCH in Montana and a strategic plan with clearly identified priorities and activities to address them. As is the case with the current plan, the new strategic plan will be reviewed and updated regularly so that it remains relevant and is useful. The Family Health Advisory Council will continue to review the plan periodically and provide external perspective on and motivation for operationalizing the strategic planning results. //2010//

An attachment is included in this section.

III. State Overview

A. Overview

Montana's geography, population size and distribution, nature of her minority groups, political jurisdictions, and economic characteristics have a profound effect on: the health of her citizens; how direct and public health services are provided; and on the enormity of health disparities in the state. These factors affect both the State's health priorities and initiatives, and the process for determining those priorities.

GEOGRAPHY: Montana is the fourth largest state in the United States, encompassing 145,552 square miles, 56 counties, and seven Native American reservations. Western Montana is mountainous, heavily forested, dotted with waterways, and state parks and state forests. The eastern two-thirds of the state is semi-arid to arid and access to water is often a concern. Annual precipitation averages less than 15 inches. Forest and range fires routinely affect local air quality and can exacerbate asthma and other respiratory conditions.

Vast distances, isolation of small communities, sparsely located ranches and farms, as well as severe winter weather can make travel extremely difficult and often dangerous, especially over icy mountain passes or through ground blizzards on the plains. Public transportation is limited, with many areas in the state totally devoid of air, rail, or bus transportation. The Insurance Institute for Highway Safety published a study of traffic safety laws in all 50 states in June 2005. The laws they rated were seat belt use, young driver licensing, DUI, child restraint use, motorcycle helmet use, and red light camera laws. Montana had the poorest ratings for motorcycle helmet use and red light camera laws, with only marginal ratings for young driver licensing, safety belt use, and child restraint use. Montana was the third highest state for motor vehicle deaths per 100,000 people in 2003, accounting for 262 deaths. For 2004, Montana ranked 50th in the nation for motor vehicle fatalities with 2.5 deaths per 100,000,000 miles driven.

POPULATION CHARACTERISTICS: U.S. Census reports the 2000 population was 902,195, 44th in terms of population, with a population density of 6.2 people per square mile. The 2004 population estimates for Montana suggest an overall increase of 2.7% from 2000, with the in-state population redistributing to the western portion of the state and into urban areas. Montana has three metropolitan areas and five areas with a population over 10,000 people. Sixty-four percent of Montanans reside in these eight areas, with the remainder of the population dispersed into smaller communities, farms, and ranches. In 2000, Montana had 0.3% of the total population of the United States, with little change projected by the census for 2004. It is projected that Montana will have an 11% increase in population from 2001 through 2015, 28th in population growth for the time interval. Projected population for 2030 is 1,044,898, ranking 27th in the nation for population growth.

The median age in Montana for 2000 was 37.5 years, higher than the national average of 35.3 years. Projections for 2030 suggest Montana's median age will increase to 46.0 years, representing a 22.7% increase in median age for the state. Montanans over 62 years of age are predicted to increase 115.6% by the year 2030, with a 0.4% decrease in children less than 18 years of age. Montana's population is split evenly between males and females. In 2000, the median age for men was 36.6 and for women was 38.5. Women of reproductive age (15-44 years) comprised 20.5% of the state population, and children and youth under 20 represented 28.5% of the population.

In 2002-2003, Montana pupils scored at or above proficiency for math, science, and reading assessments. Montana ranked 28th in math proficiency and 9th in reading proficiency, according to CFED for 2004. Montanans also tested slightly higher than the national average on the ACT, with 81% of graduating seniors taking the test. For 2003-2004, Montana had a high school diploma rate of 82.9% and a high school completion rate of 84.8%. Historically, Montana's pupil teacher ratio has been significantly smaller at 14.5 pupils per teacher than the U.S. average

of 15.9. IEP percentages (learning disabilities) were slightly higher than the national average during the time interval. For 2003-2004, Montana ranked 47th in teacher salaries ($37,184), and state budget allocations for education were significantly lower than the national average (12% difference). People in Montana 25 years old and over with a bachelor's degree or more in 2003 accounted for 24.9% of the population, ranking 27th in the nation. Estimates for 2004 suggest a 2.4% increase from 2003. Montana's university system comprises of two universities, four colleges, and five colleges of technology. In addition, there are six private colleges, seven tribal colleges, and three community colleges. Montana ranked 22nd in the nation for computer and internet presence in the home.

In 2002, Montana ranked 34th in total crime per 10,000, 29th in violent crimes, and 24th in the juvenile crime index. In 2002, Montana ranked 31st in percent of births to unwed mothers. There were approximately 13.6 TANF recipients per 1,000 population in April 2005, 87.7 food stamp recipients per 1,000 population, with the average amount of food stamps per household equal to $215.44. Both the number of cases and the average amount per case has increased steadily since 2000, according to DPHHS.

Montana is predominately white with approximately 91% of the 2000 population reporting Caucasian as the primary race, compared to 75% in the nation. Eleven American Indian tribes make up the largest minority population in Montana, representing approximately 6.2% of the total population (56,068), the 5th highest state in the nation. Estimates for 2003 suggest a 4.8% increase from 2000, with American Indian births accounting for approximately 12.2% of the births in the state. The number of people of Hispanic origin has been growing faster than other minority groups with the exception of Native Americans, demonstrating a 5% increase from 2000 to 2003 (estimate). Minority groups that may not be captured by census data, but that may have unique health issues, include migrant and seasonal farm workers and religious groups such as the Hutterites. There are also isolated pockets of other minority groups including a Southeast Asian cluster of about 200 to 300 persons in western Montana as well as about 300 Russians.

2000 Census Population Demographics

White	90.6%	Asian	0.5%
American Indian	6.2%	Black	0.1%
Hispanic	2.0%	Other	0.7%

ECONOMIC CHARACTERISTICS: Montana's economic history is one of extraction of natural resources. Currently, the majority of the land is used for agriculture and the production of oil, gas, lumber, and coal. Limited mining for copper, silver, palladium/platinum, and gold continues. However, these extraction processes have left a legacy of environmental pollution. In 2004-2005, Montana had 15 Federal Super Fund sites and 208 CERCA priority facilities. The vermiculite mines in Libby, Montana were shut down in 1990. A medical screening program conducted by the Agency for Toxic Substances and Diseases Registry (ATSDR) and the State of Montana DPHHS has disclosed that several hundred people were exposed to asbestos contaminating the vermiculite and have evidence of asbestos-related diseases. According to the EPA in 2005, small sources of vermiculite are still found in a variety of places in and around people's homes and businesses. However, air monitoring indicates it is safe to walk the streets of Libby. DPHHS Environmental Public Health Tracking was established in 2004 with support from a 3-year grant from the CDC. EPHT's vision is to better protect communities from adverse health effects through the integration of public health and environmental information, such as the Libby, Montana exposure. EPHT will improve surveillance of chronic diseases, birth defects, and developmental delays, and link health data with existing data on environmental hazards and exposures, to better inform the public regarding health concerns.

Montana also ranked 50th for employment wages, with the average annual pay equal to $26,001 for 2002 and 2003 estimates increasing only 3.3%. In 2001, at least 9.3% of employed individuals in Montana held more than one job. In December, 2004, the top five employment industries in the state were government, trade, transportation and utilities, education and health

services, leisure and hospitality, and professional and business services. Tourism is becoming a major industry -- non-state residents spent $2.7 billion in the state in 2002. Approximately 9.8 million visitors generated 43,300 Montana jobs. However, tourism jobs are typically in the service sector, which pays relatively low wages for the majority of jobs.

Federal aid to state and local governments per capita for 2003 ranked Montana 12th in the nation. Federal funds accounted for 62 cents of every dollar of state revenues spent. Resources supporting state level efforts for MCH and CSHCN are overwhelmingly federal -- less than 5% of funding for the FCH Bureau or the CSHS section is from the state general fund. Montana depends on its local partners to make up the required match for the MCHBG. Data for 2002 suggests Montana had $6,973,894 in federal funds and grants.

POVERTY: Montana is ranked 11th in the country for percent of the population below poverty level for 2000-2002. According to 2002 Census estimates, 25.5% of children under five and 16.7% of children ages five to 17 live in poverty. Overall, 14.0% of Montana's population lives in poverty, while the national average for 2000-2002 was 11.7%. Preliminary 2003-2004 data suggests Montana has 20.2% of it's children living in poverty, ranking the state 42nd in the nation. Five out of seven reservations are found in eastern Montana, an area with limited natural resources, high unemployment, and disproportionate poverty.Since 2001, Montana's unemployement rate has been lower than the U.S. According to the U.S. Department of Labor, Montana's unemployment rate in 2004 was 4.4%, compared to the U.S. rate of 5.5%. However, unemployment for the tribes ranged from 40.58% to 77.21%, with an average unemployment rate of 59.63% for 2001 Montana Progressive Labor Caucus data. Reservation data collected by Montana DLI suggests lower unemployment rates may exist. Year after year, data on poverty in Montana continues to demonstrate disparities between the population as a whole compared with the seven Indian Reservations.

Annual Average Unemployment Rates on Montana's Reservations

Reservations	2001	% Employed but below poverty	Tribes 2001
Blackfeet	70.0%	26.0%	69.93%
Crow	66.0%	16.0%	60.65%
Flathead	76.0%	22.0%	40.58%
Fort Belknap	71.0%	20.0%	70.49%
Fort Peck	63.0%	23.0%	62.54%
Northern Cheyenne	27.0%	7.0%	64.69%
Rocky Boy's	36.0%	37.0%	77.21%
Reservations Total	59.86%	NA	59.63%

In 2004, Montana ranked 20th in bankruptcy filings by individuals and businesses. Homeownership rates for 2004 data suggest 71.5% of Montanans own their home, ranking 23rd in the nation.

POLITICAL JURISDICTIONS: The state has 46 frontier counties, 8 rural counties, and only 2 urban counties. Fifty-four county health departments contract with the DPHHS to provide MCH and other health services, but the local health departments are county entities under the control of local Boards of Health, and the staff are county employees. The seven Indian reservations have nation status for 11 American Indian tribes occupying 8.4 million acres. This status, coupled with the federal role in public health on the reservations, pose jurisdictional challenges affecting coordination of county and tribal health services for common clients between the two service delivery systems. The other three tribal health clinics belong to the three "compact" tribes that staff their own clinics. Although the I.H.S. data system is used at all seven tribal health clinics, patient health data that is not entered into the system for I.H.S. staff services may not be shared with the State without separate agreements with the three compact tribes. According to the Tax Foundation, the federal tax burden on Montana is 17.5% for 2005, ranking Montana 35th in the

nation. The state and local tax burden is 9.5% for 2005, ranking the state 39th in the nation. New tax relief measures implemented in 2005, including a 10% tax bracket, child tax credits, reduction of income tax rates, and reduction of the marriage penalty, will provide benefits to thousands of taxpayers and businesses. Child tax credits, reduction of income tax rates, reduction of the marriage penalty, and other changes to the tax laws will benefit many Montanans.

ACCESS TO HEALTH CARE: Nine counties have no private medical services at all. There are 54 local county public health departments. Health care for the tribal residents of Montana is provided by a network of services including: off-reservation hospitals; clinics and practitioners; county health departments; Indian Health Service systems; and tribal health services. There are three urban Indian full-service medical clinics located in Billings, Great Falls, and Helena and two referral based clinics in Missoula and Butte. Montana ranked 15th in the nation for the percent of health dollars for public health, 19th in per capita public health spending, and 36th in adequacy of prenatal care. Montana has 21 local hospitals, 40 Critical Access Hospitals (CAHs), and 20 Community Health Centers. All hospitals provide access to care for low-income, indigent, Medicaid, and Medicare patients. There are two hospitals that provide pediatric mental health care, five provide care exclusively for veterans and American Indians and are federally owned and operated. All but the hospitals in Billings and Great Falls are classified as rural facilities by HCFA. Sixty percent of primary care physicians are located in Silver Bow, Yellowstone, Missoula, Gallatin, Cascade, Lewis and Clark, and Flathead counties, the seven most populated counties in Montana. Establishment of Rural Health Clinics (RHC), under the provisions of PL. 95-210, has improved access to health care in many counties and communities. There are 40 Rural Health Clinics in Montana and several additional sites are currently considering conversion/establishment of a RHC. There is one Migrant Health Center (MHC) in Montana located administratively in Billings. Satellite services have been provided over the last several years in six locations.

According to 2004 CFES data, Montana ranked 50th in the nation for employer-provided insurance. Low-income children and low-income parents consisted of 19.8% and 82.3% of the population for 2004, respectively. CFES gave Montana an "F" in health care for these reasons. The Bureau of Business and Economic Research of the University of Montana is studying the incidence of uninsured status in Montana and on June 25, 2003, reported the following for the Montana population under age 65: 43% of urban and 57% of rural residents are uninsured; 31% to 45% of American Indian residents are uninsured, while 18%-22% of Whites and all others lack health insurance. Most of the businesses in Montana are small businesses and cannot afford health insurance premiums for their employees. Agricultural families are often disqualified from public programs because of high assets, even with low income, and cannot pool for reduced premiums.

Oral health care had become a major public health issue. The Montana Foundation of Dentistry for the Handicapped provides free comprehensive dental care to people who are permanently disabled, medically compromised or elderly, and who cannot afford dental care. Six Montana Community Health Centers (Billings, Butte, Great Falls, Helena, Missoula and Libby) include some dental services, though the waiting lists can be long. Dental clinics are offered in thirteen locations through the Indian Health Service. Montana's point-in-time PRAMS in 2002 reiterated lack of access to dental care for pregnant Medicaid participants was a statewide problem. Data for 2004 suggests Medicaid-payable dentists are also a resource problem, with 14 counties lacking at least one Medicaid-payable dentist and 14 counties with only one Medicaid-payable dentist, representing 50% of all Montana counties. Oral health results from a statewide convenience sample of third graders for 2002-2004 suggested immediate caries were a problem for 25.1% of the sample, with a past caries rate of 50.7%, and an urgent caries rate of 6.2%.

High mortality rates are a large problem for Montana. Montana ranks 46th in the nation for occupational fatalities, with 12.3 deaths per 100,000 workers for 2004. Cardiovascular deaths for 2004 equaled 296.2 per 100,000 people, ranking 11th in the nation. Cancer deaths in Montana

ranked 23rd in the nation, infant mortality 27th in the nation, premature death 22nd in the nation, and total mortality 32nd in the nation. Leading causes of death in Montana are heart disease, cancer, cardiovascular disease, diabetes, pneumonia, chronic obstructive pulmonary disease, and accidental deaths due to unintentional injuries. For Montana Indians, accidents, diabetes, and chronic liver disease and cirrhosis follow heart disease and cancer for the leading causes of death. Whites typically die at an older age than Indians. (Montana Bureau of Records and Statistics, 2003) Montana is 2nd in the nation for death rate by suicide, at 19.3 per 100,000 population in 2001.

Drug abuse in Montana is a growing concern, especially methamphetamine use. The U.S. Drug Enforcement Administration reported 2003 federal drug seizures in Montana included 0.5 kg cocaine, 107.2 marijuana, and 8.8 kg of methamphetamine. In 2002, Montana law enforcement agencies responded to 122 meth labs statewide. BRFSS for 2003 reported 9.3% of students grades nine to 12 reported using meth at least once in their lives. The Billings area has an active methamphetamine task force while other communities scramble to become informed about the implications of meth use and the potential impact on the maternal and child populations in their areas.

Domestic violence continues to grow in scope. Statistics for 2001 suggest 7.0% of aggravated assaults were by a spouse or ex-spouse and 6.5% were from boyfriends or girlfriends. PRAMS data for 2002 suggests 8.8% of all Montana women aged 15-45 are abused before pregnancy and 5.0% during pregnancy. However, the Montana Board of Crime Control suggests reported domestic violence to be only 0.45% of the population-at-risk for abuse, suggesting underreporting is a serious issue in Montana.

CDC's State Health Profile for Montana notes childhood health concerns include birth defects, vaccination coverage, infant mortality, prenatal care, and teen pregnancy. Montana has developed a birth defects registry that now contains data for 2000 through 2004. A heightened rate of Downs Syndrome appears in the data, along with other defects of concern including gastroschisis, diaphragmatic hernia, and cardiovascular defects. The Fetal Infant Child Mortality Review (FICMR) program, authorized by the Montana State Legislature in 1997, has published two reports since its inception. There were 1,256 fetal, infant, and child deaths in Montana from 1997-2002, accounting for 1.0% of the cumulative birth cohort (N=130,694). Cumulative review percentages suggest 59.2% of all fetal, infant, and child deaths were reviewed by the 27 local FICMR teams covering 48% of the counties. Nevertheless, the program determined that 39.7% of the cumulative reviewed deaths that contained prevention findings were preventable.

Montana continues to face a health care worker shortage. During the reporting years 2001 to 2002, a task force was created and appointed by the Governor "to accurately assess the shortage of health care workers, and to develop recommendations and strategies to effectively address the issue." As of 2002, there were 2.0 physicians per 1,000 population, as compared to the U.S. average of 2.3 physicians per 1,000 population, according to the Northwest Area Foundation. This statistic ranks Montana approximately 34th in the nation. For the year 2012, DLI predicts only 2,077 physicians and surgeons for Montana, a rate of 2.1 physicians per 100,000 population, based on a 984,043 population projection. Dieticians and nutritionists are projected to reach 216, a rate of 2.2 per 100,000 population. Registered nurses are projected to reach 10,707, a rate of 10.9 per 10,000 population. However, even with all the known shortages, Montana's response has only been to establish a task force commission or panel, which is 1 out of 7 measurable responses.

In 2002, Montana ranked 44th and 47th in the nation for series of immunizations given to 19-35 month old children. In 2003, Montana ranked 24th in infant mortality at 6.8/1000 live births. Three-year cumulative average for people without health insurance coverage was 16.1% for 2001-2003. In 2002, Montana estimates indicated 54% of the adult population to be overweight or obese. The same dataset estimated the adult smoking prevalence rate to be 19.9% of the population. Smoking-attributable direct medical expenditures (state share) are estimated at $216

million. There are approximately 1,439 annual smoking-attributable deaths in Montana, according to the Center for Tobacco Cessation. Montana is 1st in the nation for adolescent male use of smokeless tobacco. In 2000, Montana ranked 35th in Medicaid recipients and 25th in state and local funding spent on health and hospitals. Montana ranked 34th in per capita spending on Medicaid recipients, 7th in average Medicaid spending per child, and 19th in Medicaid spending on aged recipients. Montana ranked 6th in the nation for hospital expenses per inpatient day at $2,573. In 2003, Montana had 47,088 enrollees in HMOs in 2003, down from 2002.

This snapshot does not tell the whole story. Montana needs nearly 1,000 more health care workers right now just to catch up to the national averages! And, as Montana's population continues to age, demand for all occupations - including those that are now adequately staffed - will rise dramatically while the health care workforce diminishes. The impact will be felt more dramatically in Montana than in most other states because of our older-than-average population

/2007/

POPULATION CHARACTERISTICS: The 2005 population estimate for Montana is 935,670, constituting a 3.7 increase from April 2000 to July 2005 http://www.census.gov/hhes/www/poverty/poverty04/stategrid.xls .

POVERTY: Census figures for 2002-2004 indicate the percent of Montana's population living in poverty is up to 14.3% http: www.census.gov/hhes/www/poverty/poverty04/stategrid.xls

ACCESS TO HEALTH CARE: Montana has eleven Community Health Centers, with seven satellite sites, one Migrant Health Center with nine satellite sites, and one Healthcare for the Homeless Program with three satellite sites. Four additional communities have submitted Community Health Center applications. Oral health services are available at eight of the centers and through two mobile clinics. http://www.mtpca.org/mtcenters.htm //2007//

/2008/ POPULATION CHARACTERISTICS: The 2006 population estimate for Montana is 944,632 constituting a 4.7 increase from April 2000 to July 2006. Population growth continues to be primarily in and around communities that are already the most urban in the state. Two exceptions are Flathead and Ravalli Counties, where population growth may be producing two new "urban" areas.. The majority of population growth since 2000 has been in counties in western and south-central Montana. The Montana Census and Economic Information Center at the Department of Commerce projects that the state population will continue to grow at similar rates for the next few years.
(http://ceic.mt.gov/Publications/Newsletter_Fall_Winter_06_07_Final.pdf)

The increases cannot be attributed to increased birth rates, which dropped to an all time low (for the last 100 years) to 12.1 from 2000 to 2002, increasing slightly back up to 12.4 for 2003 -- 2005. http://www.dphhs.mt.gov/statisticalinformation/vitalstats/2005report/2005selectedeventsrates.pdf

54 of Montana's 56 local city/county health departments providing maternal and child health services to their residents are contractually required to establish a memorandum of understanding regarding coordination of services with Indian reservations, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. The local city/county health departments are contractually required to establish a memorandum of understanding regarding coordination of services with Indian Health or Tribal Health Services, or a written description of interagency coordination efforts and a list of key personnel, if an Indian reservation is adjacent to the county. Several MCH programs, i.e. Public Health Home Visiting, Cleft Palate Outreach Clinics, are operating on several reservations with a goal for 2008 to increase the number of partnering reservations.

POVERTY: Census figures for 2003-2005 indicate the percent of Montana's population living in poverty is up to 14.4% http://www.census.gov/hhes/www/poverty/poverty05/table8.html

ACCESS TO HEALTH CARE: Montana has thirteen Community Health Centers, with seven satellite sites, as well as a Migrant Health Center that provides services statewide and one Healthcare for the Homeless Program. Additional sites continue to be under development for CHC status. Efforts to help develop the oral health services available at most of the sites are underway in the state, supported by Temporary Assistance for Needy Families funding awarded to the state. Further expansion of oral health services has also been proposed in the Targeted State MCH Oral Health Service Systems Grant Program submitted July 2007. //2008//

/2009/ POPULATION CHARACTERISTICS: The 2007 population estimate for Montana is 957,861, up from 902,195, constituting a 6.2 percent increase from April 2000 to July 2007. There were 12,499 live births to residents in Montana in 2006 -- up significantly from the last decade, where the number of births ranged from 10,779 to approximately 11,500. The birth rate of 13.2 is the highest since 1993; however, it is too early to determine if this single year increase will be continued in future years. As with many small population states, Montana's health indicators may change dramatically from year to year, leading the public and sometimes policy makers to assume associations between programs and activities and outcomes. In fact, what may appear to be dramatic changes, such as a child death rate dropping to 25 per 100,000 children aged 1-14 in 2005, down from a rate of 33 in 2000, may be due to very small changes in actual numbers.

ACCESS TO HEALTH CARE: The Montana 2007 legislature authorized funding to support a community health center based upon the federal model. Flathead Community Health Center, in Kalispell, MT is the first CHC to be funded with state dollars. //2009//

/2010/

POPULATION CHARACTERISTICS: The 2008 population estimate for Montana is 967,440, up from 902,195, constituting a 7.2 percent increase from April 2000 to July 2008. There were 12,522 live births in 2008, according to preliminary vital statistics data.

ACCESS TO HEALTH CARE: In November 2008, Montana voters approved the new Healthy Montana Kids program, which will expand coverage under Medicaid and CHIP by raising eligibility levels to 133 percent and 250 percent of the federal poverty line, respectively. The expansion, which goes into effect in October 2009, will cover as many as 29,000 of the 34,000 underinsured children in the state.

MCH SERVICES MAP: Attached is a map with the locations of MCH Block Grant funded services.

//2010//

An attachment is included in this section.

B. Agency Capacity

The Title V programs are located within the Health Resources and Public Health and Safety Divisions of the Department of Public Health and Human Services. The structure of DPHHS is described in the organizational structure section of this application. Title V efforts are primarily focused in the Family and Community Health Bureau of the Public Health and Safety Division (PHSD) and in the Children's Special Health Services (CSHS) program, which is located in the Health Care Resources Bureau of the Health Resource Division.

The Family and Community Health Bureau (FCHB) is the primary MCH agency, responsible for development of the MCHBG report and plan, budget monitoring, and implementation of the plan. The Family and Community Health Bureau has a staff of approximately 30, and a budget of approximately $21 million, from 13 funding sources including grants from CDC, HRSA, SAMHSA, USDA, the Office of Population Affairs, and Montana general fund. The largest program and budget is the WIC Program, with a budget of approximately $14 million. The MCHBG is the second largest funding source, at about $2.5 million annually. Approximately 95% of the FCHB budget is federal dollars.

Local providers are crucial partners in the provision of MCH services in Montana. Approximately 42% of the MCHBG is contracted out to local health departments to provide MCH services to the population. Of the $1.1 million of state level match, 1/2 of that is also contracted to local health departments for public health home visiting services to pregnant women and infants. The remaining $500,000+ is contracted to for genetics services for the MCH population.

FCHB is also responsible for coordinating the MCH needs assessment and subsequent further prioritization of MCH needs and strategic planning that will take place in 2005 and 2006.

The Children's Special Health Services (CSHS) program in the Health Care Resources Bureau administers 30% of the MCHBG. HCRB provides services to children in three ways: direct services to children, indirect services to children, and administrative services.

Direct services to children include cleft cranio-facial clinics, metabolic clinics and case management services, regional clinics, nutrition services, neonatal follow-up, newborn screening follow-up, medical home program, transition services, case management, care coordination, clinic coordination, systems of care development, dental services, vision services, hearing aids, medical services, enrollment, and medical reviews.

Indirect services to children include: outreach, cultural competence, plan relations, provider relations, advocate liaison, enrollee education/newsletter, quality assurance/improvement, customer service, family support and referral, health care integration for access, coordination and referral, policy development and review, complaint processes, web page development and maintenance, and data systems development and coordination.

Administrative services include: office and facilities management, personnel management, labor-management relations, state/federal coordination, CHIP State Plan, MCH Block Grant submission, administrative rules, file and chart systems, research, professional development, surveys, technical assistance, contracts, waivers, payroll, new employee orientation, communication, budget and fiscal, performance measurement, grant writing, safety and security, program evaluation, legislative support, congressional requests, public relations, and purchasing and inventory.

Co-location of the CSHCN program with the CHIP program has facilitated coordination of applications for services for children between those two programs, Medicaid, and other programs, which may benefit children and their families. The HCRB Bureau manages the Family Health Line, which is the Title V toll free line, directing callers to programs within DPHHS and around the state. The Children's Mental Health Bureau is also located in the HR Division. That bureau is directing development of the Kid's Mental Health Services Areas or KMA's in the state, which may address and improve the mental health service needs of the MCH population.Services are provided to Montana children with special health care needs and their families by the CSHS program staff and their contractors.

Services include specialty clinic services, direct payment of medical services for eligible children who have no source of payment for needed care, identification and referral of children with special health care needs, and consultation and technical assistance. The number of children receiving direct pay services has decreased as insurance coverage becomes more available. In

Montana, CSHCN program eligibility is based on diagnosis/condition and financial eligibility. Montana does not have a medical school or a school of public health, and relies on partnerships with private providers to develop and deliver services to the vulnerable populations. The CSHS has developed partnerships with two hospitals in Missoula and Billings for regional specialty clinic services, and is working towards development of a third regional clinic site in Great Falls. The Montana Legislature included a line item to support additional regional clinic development in the 2005 session. Program staff is developing the ability of clinics to bill for services, which will diversify funding available to support these sites, which have been primarily supported by hospital in-kind and MCHBG contract funds to date.

CSHS continues to foster relationships with non-profit organizations dedicated to children's issues. Parents Lets Unite for Kids (PLUK) is a longstanding advocate for parents and families, and the host organization for Montana's Family Voices chapter. Work with PLUK has centered on collaboration to improve access to community-based, family-centered services for CSHCN.

The Family and Community Health Bureau's mission is the "promote the health and well being of Montana's citizens to help healthy families build health communities." The bureau is organized into four sections: the MCH Data Monitoring (MCHDM) section, the Child, Adolescent and Community Health (CACH) Section, the Nutrition/WIC Section and the Women's and Men's Health Section. MCHBG funding and program efforts are primarily located in the MCHDM and CACH sections.

The MCHDM section manages the 54 local MCH services contracts, oversees the MCH block grant development and performance measure monitoring, and is responsible for the population based newborn metabolic and hearing screening programs. That section has also housed the Point in Time Pregnancy Risk Assessment Monitoring project from 2001 -- 2004; the state intends to apply for CDC funding to reinitiate the program in 2005. The MCHDM section also manages the state's genetics program and contract, which is funded with a tax on individual insurance policies. Legislative changes in 2005 resulted in an increase of that funding source, which will in turn result in a reassessment of contractor role and services.

The MCHDM section houses Montana's birth defects registry, the Montana Birth Outcome Monitoring System (MBOMS), which was initiated with CDC funding in 2000. The population-based registry identifies and refers children in need of services to the CSHCN and other appropriate services. Initially, the program was a passive case ascertainment system, focusing on four major anomalies - congenital hypothyroidism and cleft-craniofacial, cardiac, and neural tube defects. CDC recommended active case ascertainment, which was added in 2001. The program was funded for an additional three years of CDC funding in 2002. A renewal application submitted in early 2005 was reviewed, approved, but not funded, leaving the future of the registry in question. At present, the registry, including the active case ascertainment will be continued with carry over dollars, supplemented as possible with MCHBG. The long-range feasibility of continuing this support continues to be in question, especially in view of the MCHBG decreases over the last several years. Birth defect monitoring efforts continue with grant carryover and MCHBG funding at this time -- partnerships with the state's Environmental Public Health Tracking program are being explored. The registry has helped identify and inform investigations of what appeared to be high instances of Down Syndrome and gastroschisis in Montana over the last several years. The gastroschisis investigation continues with the help of student efforts from the Rollins School of Public Health at Emory University.

Montana's "heelstick" newborn screening follow up has been housed in the FCHB since 1995 and is a part of the MCHDM section. Follow up efforts continue to be a partnership between medical providers and hospitals, the public health laboratory, parents, the FCHB and the CSHCN program. Montana presently screens for four department-required blood tests for PKU, galactosemia, congenital hypothyroidism, and hemoglobinopathies. Interest in adding additional tests has been expressed by the medical community, but in light of fiscal constraints and resistance to increases in existing lab charges, no additional lab screenings have been mandated

in the last few years. Montana is monitoring national efforts to recommend additional screening tests in the future. At present, our state lab, which conducts newborn screening for the state, lacks mass spectrometry equipment, which will be necessary for inclusion of some of the additional tests. The lab presently works with out of state labs to facilitate provider requests for additional testing.

Newborn hearing screening is also coordinated by the MCHDM section, in conjunction with the metabolic screening program and the birth defect registry. Montana has increased capacity for newborn hearing screening in the state, moving from approximately 30% of newborns tests 4 years ago to more than 80% at present. The state and the advisory group for this program now face the difficult task of how to facilitate screening in the very small communities where limited resources for testing and follow up exist, and to assure effective follow up, especially in small communities. The group will be examining various approaches to this challenge in FFY 2006.

The MCHDM has been the lead player in development of standardized reporting capacity for local public health, concentrating on MCHBG and PHHV reporting requirements. The Integrated Data for Evaluation and Assessment (IDEA) Project was designed in 1998 to provide improved support for the delivery of maternal and child health-related services at the state's local public health departments and to improve local and state capability for evaluation of program effectiveness. The Public Health Data System (PHDS) was developed for use at local health departments to support their client case management and reporting capability. PHDS has been designed to support four of the public health programs provided at the local level -- client case management and tracking, an initiative to serve women with high risk pregnancies, family planning and immunizations. The immunization component will include: population of the immunization registry with birth record data; immunization data from the Indian Health Service and participating tribal health departments; and linkage with private providers of immunizations. Interface of the PHDS with the Indian Health Service data system in use in Montana's tribal health department stalled when the IHS decided to establish its own national immunization registry interface protocol for use by all states. The PHDS has been rolled out to 83% of the local public health departments, and plans to convert the web based structure with increased ease of data entry is presently in process.

In 1985, the Montana legislature authorized the creation of a voluntary statewide genetics program, funded by a tax on individual insurance policies. The program provides for newborn heelstick screening follow up, and genetic services and education for the people of Montana. FCHB provides the newborn screening program follow up, referring children identified with metabolic disorders to the CSHCN and genetics programs for intervention and evaluation. In 2004, a formal request for proposal (RFP) process was undertaken to award a new contract for clinical genetic services for Montana after more than a decade of annual renewal of the existing contract. A new contract has been awarded to the previous contractor and services and reporting requirements have become more clearly focused. The 2005 Legislature considered and passed a bill increasing the tax on individual insurances, which provides the funding to support the program. This increase sunsets in 2007, requiring the department to investigate alternative mechanism to fund the programs, with a goal of increasing the base upon which the funding depends.

The Child, Adolescent and Community Health Section houses many of the staff and programs most directly impacting the MCH population. Staff in the section manage and monitor the public health home visiting program for pregnant women and infants, the fetal infant child mortality review, the SIDS prevention, fetal alcohol prevention and youth suicide prevention programs, the early childhood comprehensive systems project, the oral health program, and provides consultation on general child, school and adolescent health issues.

The public health home visiting (PHHV) program has a long history in the state. In 1989, the Montana Legislature enacted legislation establishing the Montana Initiative for the Abatement of Mortality in Infants (MIAMI) and supporting it with general funds. The goals of the legislation

compliment the charges in Title V of the Social Security Act, which are to 1) assure that mothers and children, particularly those with low income or with limited availability of health services, have access to quality maternal and child health services, 2) reduce the incidence of infant mortality and the number of low birth weight babies and 3) to prevent of the incidence of children born with chronic illnesses, birth defects or severe disabilities as a result of inadequate prenatal care. The program has continued to evolve, with efforts in 2004 targeting focusing the program on pregnant women and infants, and emphasizing home visiting as the preferred mechanism of providing services. At present, there are 19 contractors for PHHV services, including three tribal programs.

Montana's oral health program is also located in the CACH Section. The oral health program focuses on population based and infrastructure services to develop community awareness of the importance of oral health and to build capacity at the state and community levels. The program has benefited from the State Oral Health Collaborative Systems grant program, which has facilitated focus on system development. The oral health program coordinator has worked with the Primary Care Office and Primary Care Association over the last several years to focus education and cooperation regarding the importance of oral health and the serious access issues that exist in our state. The oral health program also coordinates school-based efforts to enable schools to conduct dental screening and fluoride rinse programs, and works in conjunction with the WIC, Head Start, Healthy Child Care Montana and the Child, Adult Care Food Program to develop appropriate services for the pre-school population. Training materials for public health and dental professionals were supplied to dental screeners and data recorders on a case-by-case basis to assure standardization and utilization of the Basic Screening Survey (BSS) surveillance instrument developed by the Association of State and Territorial Dental Directors (ASTDD).

The CACH section also supports efforts to prevent Fetal Alcohol Syndrome and Effect through prenatal prevention efforts. This effort was first supported by Congressional set-aside funding focusing on South Dakota, North Dakota, Minnesota and Montana. The project funded $3 million dollars per year to develop a three component effort which included 1) the creation of a Four State FAS Consortium, charged with program development, implementation and evaluation, 2) assessment which included gathering of consistent data with which to accurately assess the incidence and impact of FAS in the region and 3) intervention projects, focused on the prevention of fetal alcohol syndrome and fetal alcohol effect. Montana's intervention was built upon the PHHV/ MIAMI project, adding intensive home visiting and case management for pregnant women at risk of having a child with FAS/FAE. The project also enabled collaborative efforts to support FAS evaluation clinics in the state. Funding for the four-state consortium was no longer earmarked in 2004, and the staff applied for and received a Fetal Alcohol Syndrome Centers for Excellence award from SAMHSA in 2004.

The Fetal Infant and Child Mortality Review (FICMR) program directs and guides local efforts to review deaths of fetuses, infants and children 18 years of age or younger. The purpose of the review is to enable communities to identify risks or challenges in their communities and to implement appropriate prevention measures. State level functions are to compile and examine data looking for patterns and clues indicating statewide and/or legislative policy changes required. Examples of the uses of FICMR data include testimony to the 2005 Montana legislature regarding the importance and need for a graduated driver's license for young drivers, primary seat belt laws for children, and standardized medication administration policy in day care settings. The data was lauded by MCH advocates as useful and supportive of preventive efforts for the MCH population.

SIDS prevention is an ongoing effort in Montana, as in other states. A recent innovation has been the availability of a "Safe Sleep" program, providing safe cribs to needy families across the state. Public Health Nurses in counties and tribal settings may request cribs on behalf of clients who require a safe sleep environment for an infant. Requests for cribs are processed through public health nurses, and the cribs are then ordered and delivered to the public health nurse for delivery to the client. The added benefit of PHN contact and education regarding a safe sleep environment and other preventive information has been a major selling point for the program.

Support for the program has been received by the Montana Healthy Mothers, Healthy Babies Coalition, private foundations and the Emergency Medical Services for Children Program.

CACH also provides technical assistance and consultation to local public health and school staff on matters impacting child, adolescent and school health. Efforts to continue general support and development of preventive and supportive Adolescent Health Efforts to develop strong adolescent health services continue with emphasis on the two top causes of morbidity and mortality in Montana: unintentional injury and suicide.

Suicide has, and continues to be recognized in Montana as a major public health concern. The department worked in conjunction with mental health provider, advocates, local partners and others to develop the first Suicide Prevention Plan, which was finalized in 2001. Funding was also obtained from the Governor's office in 2004, and from Preventive Health Block Grant carryover in 2005 to conduct an assessment of resources for suicide prevention in the state, and to support local efforts to prevent youth suicide. A report of the status of effort is attached to this document. DPHHS partnered with others to submit an application for a SAMHSA Cooperative Agreement to address youth suicide in June of 2005.

The Family Planning program receives a small amount ($25,000) of MCHBG funding which it includes in the contracts with 15 local agencies to provide family planning services in 38 locations. Family planning programs are designated STD programs and all programs have enrolled medical service providers that provide comprehensive breast and cervical screening services to an identified target population. The family planning program serves approximately 28,000 men and women annually, including adolescents. The program helps to decrease the incidence of unintended pregnancies and births to teen mothers, which are MCHBG performance measures.

Statutory Authority for Maternal and Child Health Services Authority for maternal and child health activities within the Department are found in the Montana Codes Annotated (MCA 50-1-2020. General powers and duties of the state include administration of federal health programs delegated to the states; rule development for programs protecting the health of mothers and children (including programs for nutrition, family planning services, improved pregnancy outcomes, and Title X and Title V); accept and expend federal funds available for public health services, and use local health department personnel to assist in the administration of laws relating to public health.

Rules implementing the above authority are found in Title 16, Chapter 24, and sections 901 through 1001 of the Administrative Rules of Montana (ARM). These rules define the State Plan for Maternal and Child Health, including crippled children, family planning and school health. A 1996 addition to the Rules describes the Standards for Receipt of Funds for Maternal and Child Health Block Grant. Newborn screening is required through ARM 16.24.201 through 215. MCH 50-19-301 through 323 authorized and describes the MIAMI project. Administrative rules describing and authorizing case management for high-risk pregnant women are contained in ARM 46.12.1901 through 1925.

/2007/ The Family and Community Health Bureau continues to be the agency within the Montana Department of Public Health and Human Services primarily responsible for services for the maternal child health population. The Bureau has reorganized over the last year. Children's Special Health Services, which is Montana's program for children with special health care needs, has rejoined the bureau and public health division. Major changes in program organization and responsibilities are highlighted here:

Child, Adolescent and Community Health (CACH): This section continues to be responsible for programs and services targeting the childbearing and childrearing populations, offering supportive programs in partnership with local agencies. CACH supports and promotes the Public Health Home Visiting (PHHV) program, which is part of the Montana's Initiative for the Abatem,ent of

Mortality in Infants legislation, which was passed in 1989. The initiative included community based efforts to work with high risk pregnant women and infants. The programs provides funding and training to 19 communities, including three tribal programs. The section also supports targeted efforts to identify and support families at risk for Fetal Alcohol Spectrum Disorder, by enhancing the PHHV with the addition of staff able to provide intensive home visiting services for these families. CACH was awarded a Garrett Lee Smith Memorial Grant in 2005, continuing and greatly expanding efforts to develop youth suicide prevention programs in communities across the state. The section is responsible for the Fetal Infant Child Mortality Review and for SIDS prevention efforts in the state. Staff includes the school health and adolescent health consultants.

Children's Special Health Services (CSHS): This section is responsible for system development and service support for children with special health care needs and their families. This section rejoined the bureau on January 1, 2006, and is responsible for regional speciality clinic development, family support enhancement (in conjunction with the state's Family Voices), and limited direct pay for services. The program works closely with clinic sites and with other programs serving CSHCN and their families, including Part C and the Montana School for the Deaf and Blind. The Newborn Hearing and Metabolic Screening Program and the Birth Defects Registry was moved to the CSHS section in spring of 2006, in order to promote and coordinate clinical follow up and tracking.

Maternal and Child Health Data Monitoring: This section is responsible for development and monitoring of the Maternal and Child Health Block Grant. The section has contracts with 54 of Montana's 56 counties, distributing approximately 42% of the MCHBG award locally to support MCH services identified by and monitored through ongoing community needs assessments. The section also supports abstinence education programs with Abstinence Education funding, and is responsible for the Oral Health Program, which was moved from the CACH section.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC): The WIC/Nutrition Section administers the WIC program in Montana, which offers services through 29 contracts statewide and on in all reservation communities. The section also supports a Farmer's Market Program for WIC clients in select communities.

Women's and Men's Health: This section is primarily responsible for reproductive health services through Title X supported clinics across the state. The section monitors and supports community based efforts to prevent teen and other unintended pregnancies.

The Bureau staff and Advisory Council has developed a strategic plan based upon the information obtained through the MCH Needs Assessment in 2005. Priority needs were established and section activities developed in response to those needs.

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/

The Family and Community Health Bureau, Montana's Title V Agency, continues with the basic structure of five sections as described in the 2007 update. The Abstinence Education grant was housed and funding distributed to local partners through the Maternal Child Health Data Monitoring (MCHDM) section. Montana, along with most states, received notification of the need to increase efforts to monitor and verify compliance with grant component in late 2006. After careful analysis, staff within the MCHDM section and FCH Bureau determined that the requirements were burdensome and would require that we decrease local funding in order to support the state infrastructure necessary to comply with requirements. With the support of the

Deparment Director and staff from the Governor's office, Montana notified the Administration of Children and Families in January, 2007, of their intent to not accept Abstinence Education Funding beginning with the 2007 FFY.

The Early Childhood Comprehensive Systems grant, which had been housed in the Child, Adolescent and Community Health Section was moved to MCHDM in the spring of 2007. The MCHDM has also submitted a competitive application for the new Targeted State MCH Oral Health Service Systems Grant Program.

Two "units" consisting of focused responsibilities with staffs of two or less have been created during the last year. The first is the MCH Epidemiology Unit, responsible for overseeing the State System Development Initiative (SSDI) grant and advising on and conducting epidemiological analyses and evaluation projects across the bureau.
We were very pleased to hire the Public Health Prevention Specialist assigned to Montana 2003 -- 2006 as our first epidemiologist, and are presently recruiting a second to join the Epi Unit.

The Primary Care Office is the second unit structure within the Bureau. The Primary Care Offices' responsibilities focus on facilitating federal designation of health professional shortage areas, and of supporting recruitment efforts for primary care, oral health and mental health professionals. This section was previously located elsewhere in the division, and compliments the efforts of the Bureau staff to promote and support access to quality health care for the MCH population in the state.

The Governor's Office continues to identify Council members to be appointed to the Family Health Committee, which replaces the Family and Community Health Advisory Council. The Governor's Office announced the new and continuing members on the Council on August 15, 2008.

The Bureau continues to encourage and support staff development through internal and external training opportunities. In the past year, staff attended cultural competency and diversity trainings, as well as Communication and Team Building Skills. Additionally, the Public Health and Safety Division has provided leadership training to all management staff and is providing communication training to all division staff in September 2007. An outgrowth of the managerial training was the creation of the Employee Feedback Group, composed of a representative from each of the five FCHB's sections that meets quarterly and provides feedback to the Division on the effectiveness of the managerial specific trainings. As of September 2007, the Family Health Council has been appointed by the Governor, and the first meeting has been scheduled for the end of October 2007. //2008//

/2009//

The Family and Community Health Bureau comprised of five sections and two units, continued as Montana's Title V Agency. This past year the FCHB modified several sections with the goal of improving the Bureau's ability to efficiently provide maternal and child health services despite the continued decline in block grant funding.

Child, Adolescent and Community Health/CACH: CACH will be directing their energies this coming year on improving perinatal health through the Public Health Home Visiting/ Fetal Alcohol Spectrum Disorders Program and furthering the preventative efforts identified by the 29 Local FICMR teams. Staff is coordinating the Public Health Home Visiting Reassessment Process, involving public health home visiting program as well as working on the 2005-2006 FICMR Report. The Child Health Coordinator position was not refilled due to funding limitations, and the adolescent/youth suicide prevention position is being transferred with the Youth Suicide Prevention to the Addictive and Mental Disorders Division.

Children Special Health Services/CSHS: January 2008 witnessed the beginning of the

implementation of mandated screening of all Montana newborns for 29 conditions as recommended by national screening standards, and the addition of the Newborn Screening Program Specialist. The CSHS Supervisor tendered her resignation effective May 9, 2008; therefore, the Bureau is in the process of interviewing for this position. Clinic billing continues to supplement the three Regional Pediatric Specialty Clinics.

Maternal and Child Health Coordination/MCHC: After numerous planning sessions, it was decided to rename the section the MCH Coordination Section and to transfer the Data Coordinator position to the Epi Unit. The term coordination more accurately describes the section's focus, which includes oversight of the local public health departments providing MCH services, coordinating the Department's annual Spring Public Health Conference; and oral health care resources.

Women's, Infants, and Children/WIC: WIC is making steady progress of converting their current electronic data collection tool to the new SPIRIT system with an implementation date in late 2009. A WIC Futures Study Group, composed of lead local public health officials, local program, and state WIC Staff, was formed this year to discuss the current and future WIC allocation of funds, program direction and how to provide quality WIC services into the future.

Women and Men's Health/WMH: WMH recently published The Trends in Teen Pregnancies and Their Outcomes in Montana From 1991 - 2005 Report. The 2006 data shows that the teen pregnancy rate continues to drop for 15-19 year olds and is currently 47.8/1,000 representing a 21.8% reduction from the 1995 rate of 61.2/1,000. http://www.dphhs.mt.gov/PHSD/Women-Health/documents/teenpregnancyreport.pdf WMH's article Teen Pregnancy Prevention Month: Adolescent Health Viewed Through Teen Pregnancy was featured in the May 2008 Montana Public Health: Prevention Opportunities Under the Big Sky. www.dphhs.mt.gov/PHSD

Epidemiology Unit/Epi: The Epi Unit was enhanced with the hiring of a second maternal and child health epidemiologist, who will be begin work the middle of August 2008. The Data Specialist position is currently being advertised, with an anticipated start date in September or early October.

Primary Care Office Unit/PCO: The PCO was one of the first states in the nation to complete an analysis of the impact of the new designation methodology on health professional shortage areas. A contract with the Area Health Education Consortium was initiated in Spring of 2008 to coordinate and enhance recruiting and retention services in the state.
//2009//

/2010/
The Family and Community Health Bureau remained as Montana's Title V Agency, with one section undergoing a name change to be more reflective of their MCH activities. The Child, Adolescent and Community Health/CACH was renamed to the Infant, Child, and Maternal Health Section (ICMHS) because of its oversight of the public health home visiting project and working with communities for identifying as well as implementing prevention measures to reduce the number of preventable deaths. In the past year, ICMHS hired a nurse as the FICMR Coordinator and qualified candidates are being interviewed for the Public Health Home Visiting (PHHV) Project Coordinator position. The PHHV Reassessment Project has generated eight health improvement priority areas for pregnant women and infants which will be addressed this coming year.

The new supervisor for the Children with Special Health Care Needs (CSHS) Section formerly worked in the Medicaid Program, and has been instrumental in working with the ICMHS Supervisor on examining Targeted Case Management for the PHHV Project and CSHS clients. A Department level decision was made to relocate the Newborn Screening Position to the Department's Laboratory Services Bureau effective July 1, 2009; however, CSHS will continue to provide oversight of the Newborn Screening Follow Up Program.

The CSHS staff continued with their efforts to secure Medicaid, CHIP, and private insurance payments for services provided at their regional clinics, with the revenue being reinvested in the CSHS programs and services.

The Bureau's second epidemiologist began in August of 2008 and has completed a number of oral health data reports, one of which was a summary report of the 2007-08 School Based Fluoride Mouthrinse Program. The Data Coordinator position was filled internally by the Maternal and Child Health Coordination (MCHC) Section Administrative Assistant. The Lead MCH Epidemiologist wrote an application for a Graduate Student Intern for the summer of 2009, which was accepted. The GSIP student is working on the 2010 MCH Block Grant Needs Assessment Project, under the supervision of the Lead MCH Epidemiologist.

The MCHC Section Supervisor was accepted into the Rocky Mountain Public Health Education Consortium (RMPHEC) MCH Certificate Program and will complete the program in September, 2009. The Section also hired a new Financial Specialist in October, 2009 who is responsible for all the Bureau's budgets, except the Women's and Men's Health Section and just recently hired an Administrative Assistant whose first day was July 6, 2009. The Oral Health Education Specialist resigned in March, 2009 and the decision was made to replace this position with a Health Education Specialist. Their duties will include working more closely with the local MCH contractors on their activities related to the performance measures, as well as oral health related activities.

The Women's and Men's Health Section (WMH) welcomed a new Health Education Specialist, who formerly worked in the Division's Tobacco Program. WMH has expanded their male reproductive services, due in part to successfully applying for and receiving Office of Population Affair's (OPA) additional special initiative funds. Communication with their Delegate Agencies and other interested stakeholders is now being done through a weekly electronic newsletter. The WMH Supervisor was presented with an award of excellence for outstanding state family planning administrator from the National Family Planning and Reproductive Health Association.

The Women's, Infants, and Children (WIC) Section has also developed an electronic newsletter that is sent to the WIC locals and other interested stakeholders. As the implementation date for the new web-based WIC Data system, M-SPIRIT, draws nearer, the WIC staff has scheduled numerous training opportunities on M-SPIRIT, which also includes training on the new food package. Additional stimulus funding will be used to encourage the new food package change, the ability to purchase fresh fruits and vegetables as well as enable WIC to "re-brand" their image to correspond with the upcoming changes. WIC also added a new staff member.

The Primary Care Officer (PCO) and the MCHC Supervisor collaborated on an oral health grant, which if funding is awarded in September 2009, would increase the numbers of infants and children receiving preventive oral health care services. The PCO also submitted a grant for a National Health Service Corps State Loan Repayment Program to support health professional recruitment and retention.

The Bureau has produced a number of reports outlining their work on a number of MCH activities. The Epi Unit assisted the ICMH Section in writing the 2005-06 FICMR Report and the Public Health Home Visiting Report. The MCHC and Epi Unit reported on the 2007-08 School Based Fluoride Mouthrinse Program.

The Bureau also provided information for the Governor's American Indian Nations (GAIN) tribal relations reports, with the most recent, Tribal Relations Report 2008: The Art of Cooperation, found at http://gain.mt.gov/docs/2008_Tribal_Relations_Report_Web.pdf . To access additional GAIN information go to: http://gain.mt.gov/reports.asp.

In December 2008, each FCHB section had a representative at the Governor's Tribal Relations Training, which is required by House Bill 608. (See the attachment). This training aided the FCHB in their ability to secure a Native American speaker for the 2009 Spring Public Health Conference. The Public Health and Safety Division sponsored Investment in Excellence training for the entire Division staff and 13 FCHB staff members completed the training.

The Employee Feedback Group, initiated in 2008, recommended that each of the Bureaus within the Division be involved with the process of identifying measurable goals as related to the Division's Strategic Plan. The FCHB worked with an independent contractor in May, 2009 and identified several goals and action steps. The Division Administrator and Bureau Chiefs considered all the Bureau's suggestions. The Blueprint for Maternal and Child Health in Montana outlines the additional goals that the FCHB will address in the coming year.
//2010//

An attachment is included in this section.

C. Organizational Structure

The Montana Department of Public Health and Human Services (DPHHS) is the state agency responsible for the programs and services, which safeguard the health and welfare of Montanans. The department mission is "improving and protecting the health well-being and self reliance of all Montanans." The Director, Robert Wynia, MD oversees the agency, its 3,000 employees and approximately 2,500 contracts and 350 major programs. DPHHS has a biennial budget of about $2 billion.

The Department of Public Health and Human Services (DPHHS) is a " mega agency" encompassing health and human services for the state of Montana. Statewide reorganization of health and human services agencies in 1995 created DPHHS by combining the Department of Social and Rehabilitation Services, the Department of Family Services, and parts of the Department of Health and Environmental Services and the Department of Corrections. During the reorganization, the environmental component of public health was separated and those functions now are carried out by the Department of Environmental Quality.

The reorganization combined public health and Medicaid services into a single division, knowns as the Health Policy and Services Division. In 2003, that division was split to create the Health Resources Division and Public Health and Savety Division.

The DPHHS Director's Office includes staff and programs that support the attainment of the department goals and the divisions' efforts to implement programs. The department has one deputy director, John Chappius, who also functions as the state Medicaid director. Programs within the director's office are; the Prevention Resource Center; the Office of Planning, Coordination, and Analysis; the Office of Legal Affairs; the Human Resources Office; and the Public Information Office. The Department's four broad goals are:

All Montana children are healthy, safe and in permanent loving homes.
All Montanans have the tools and support to be as self-sufficient as possible.
All Montanans are injury free, healthy and have access to quality health care.
All Montanans can contribute to the above through community service.

DPHHS is organized into eleven divisions. They are:
Addictive and Mental Disorders Division;
Child and Family Services Division;
Child Support Enforcement Division;

Disability Services Division;
Fiscal Services Division ;
Health Resources Division;
Human & Community Services Division;
Operations and Technology Division;
Public Health and Safety Division;
Quality Assurance Division, and
Senior and Long Term Care Division.

The majority of state level activities and services to the maternal and child population take place within the Public Health and Safety Division (PHSD). The mission of PHSD is to "Improve and protect the health and safety of Montanans." Jane Smilie has been the administrator of the Division since January 2005. The Public Health & Safety Division (PHSD) oversees the coordination of the public health system in Montana. The State's public health system is a complex, multi-faceted enterprise, requiring many independent entities to unite around the goal(s) of health improvement and disease prevention at the community-level. These entities include local City/County Health Departments, private medical providers and hospitals, local Emergency Medical Services, Emergency Management agencies and other units of local government. The public health system is a part of the continuum of care available to the citizens of Montana and the PHSD promotes and supports both the availability and the quality of public health services available to Montanans. The Division is organized into six bureaus:

Chronic Disease Prevention & Health Promotion Bureau - Todd Harwell, Bureau Chief
Communicable Disease & Prevention Bureau - Bruce Deitle, Acting Bureau Chief
Family and Community Health Bureau - JoAnn Dotson, Bureau Chief
Financial Operations and Support Services Bureau - Dale McBride, Bureau Chief
Laboratory Services Bureau - Anne Weber , Bureau Chief
Public Health Systems Improvement and Preparedness Bureau - Bob Moon, Bureau Chief

The Health Resources Division admisistrator is Chuck Hunter. The division brings together health resources for children, including CHIP, Children's Special Health Services, and the Children's Mental Health Program. In addition to the children's services, the division houses the primary care and hospital portions of Medicaid. This division is organized into six bureaus:

Acute Services Bureau -- Duane Preshinger, Bureu Chief
Children's Mental Health Bureau -- Pete Surdock, Bureau Chief
Fiscal Services Bureau -- Beckie Beckert-Graham, Bureau Chief
Health Care Resources Bureau -- Jackie Forba, Acting Bureau Chief
Hospital and Clinical Services Bureau -- Brett Williams, Bureau Chief
Managed Care Bureau -- Mary Angela, Bureau Chief

Maternal and Child Health Services as described in the Title V of the Social Security Act are the responsibilities of the Family and Community Health Bureau (FCHB) and the Health Care Resources Bureau (HRB).

The Family and Community Health Bureau has a staff of 30 and a total budget of approximately $21 million. The FCHB manages approximately 300 contracts with local providers for MCH services including primary and preventive services for women, infants and children, family planning services, tribal programs and WIC. Approximately 91% of the total bureau budget is expended at the local level. The FCHB bureau is organized into four sections, which are:

Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Maternal Child Health Data Monitoring -- position vacant
WIC/Nutrition -- Chris Fogelman, Supervisor
Women's and Men's Health -- Suzanne Nybo, Supervisor

The Health Care Resources Bureau (HCRB) has 18 staff members and an annual budget of approximately $16 million. The bureau is organized in two sections:

Children's Special Health Services (CSHS) -- BJ Archambault, Acting Supervisor
Children's Health Insurance Plan (CHIP) -- Jackie Forba, Supervisor.

An organizational chart of the Montana Department of Public Health and Human Services is available at http://www.dphhs.state.mt.us/aboutus/orgcharts/orgchart.shtml. Organizational charts for the Public Health and Safety Division, the Family and Community Health Bureau, and a combined Human Resources Division and the CHIP/CSHS Bureau are attached as a single document.

/2007/ The Department of Public Health and Human Services had a new director appointed in 2005. Joan Miles, JD, is the former director of the Lewis and Clark County health department. Director Miles also worked as a clinical labortorian in the state and was a Montana state legislator.

The Family and Community Health Bureau has a staff of 32 and a total budget of approximately $21 million, including funding from 13 federal and state sources. The FCHB bureau management includes:

Family and Community Health-- Jo Ann Walsh Dotson, Bureau Chief and MCH Director
Child, Adolescent and Community Health (CACH) -- Deborah Henderson, Supervisor
Children's Special Health Services (CSHS) -- Mary Runkel, Supervisor and CSHCN Director
Maternal Child Health Data Monitoring (MCHDM) -- Ann Hagen-Buss, Supervisor
WIC/Nutrition -- Joan Bowsher, Supervisor
Women's and Men's Health -- Colleen Lindsay, Supervisor //2007//

/2008/

The FCH Bureau is very lucky to have retained the excellent managers recruited in 2005 and 2006. The listing of bureau leadership is the same as the list included in the 2007 update. Searches are in process for a second epidemiologist, and for quality assurance/contracts specialists in CSHS, WIC, and WMH. As of September, 2007 the WIC and WMH sections are fully staffed. //2008//

/2009/

The Family and Community Health Bureau staff remained fairly stable this past year. A second MCH epidemiologist will begin working in August 2008 and a new Children's Special Health Services Section Supervisor has been hired.

MCH BG funding cuts lead to the decision not to rehire the School Health Coordinator Position, resulting in the formation of new partnerships with the Injury Prevention Coordinator within the Chronic Disease Prevention and Health Promotion Bureau and the Statewide Suicide Prevention Coordinator housed in the Addictive and Mental Disorders Division. A Memorandum of Understanding with the Human and Community Services Division has enhanced the FCHB's Public Health Home Visiting Program and diversified the oral health services to include a free, online preventative oral health care training for Head Starts and Early Head Start Programs and child care providers and funding 18 Community School Readiness Teams to sponsor community events focusing on the importance of early oral health intervention.

Each FCHB Section and Unit regularly updates their respective Activity Plans, the foundation for addressing the health needs of the maternal and child population. The individual Activity Plans are based on the continually evolving Blueprint for Maternal and Child Health in Montana, which relates to the Public Health and Safety Division's Strategic Plan as well as the Bureau's 2007

Legislative Goals.

http://www.dphhs.mt.gov/orgcharts/orgchart.shtml
http://www.dphhs.mt.gov/PHSD/org%20charts/PHSD-org-charts.shtml

//2009//

/2010/

The Department of Public Health and Human Services has undergone changes in the past year. In November 2008, the Governor appointed Anna Whiting Sorrell as the Director of DPPHS. Director Whiting Sorrell has enacted changes to the DPHHS management structure, with Vital Statistics now being housed in the Public Health and Safety Division. http://www.dphhs.mt.gov/orgcharts/orgchart.shtml

The Governor's Budget reflected the nationwide economic downturn, as effective 7/1/09 through 6/30/11 all agencies are mandated to provide for at least 7% in vacancy savings and requests for hiring replacement staff and out-of-state travel must be approved by the Director. Additionally, no new programs were funded and current programs were level funded.

The Family and Community Health Bureau modified the name of the Child, Adolescent and Community Health (CACH) to the Infant, Child, and Maternal Health (ICMH) Section, which is more descriptive of their programs. The Bureau also welcomed several new staff members: a FICMR Coordinator in the ICMH Section; a Financial Specialist, who oversees all the Sections' budgets, except Women's and Men's Health (WMH) and an Administrative Assistant for the entire Bureau, in the Maternal and Child Health Coordination (MCHC) Section; a Data Coordinator in the Epidemiology Unit; and a Health Education Specialist in WMH. Interviews are taking place for the Public Health Home Visiting Coordinator housed in the ICMH Section. The FCHB organizational charts are available at: http://www.dphhs.mt.gov/PHSD/org%20charts/PHSD-org-charts.shtml

Funding constraints resulted in the Bureau replacing the Oral Health Education Specialist with a general MCH Health Education Specialist (HES), with interviews scheduled for the middle of July. The HES will primarily be responsible for working with the local health departments and MCH Partners on the state's performance measures, with minimal time spent specifically on oral health care.

The Blueprint for Maternal and Child Health in MT continues to serve as the Bureau's guiding principle for addressing the health needs of the state's MCH population. The Blueprint and the attached partnership maps reflect the numerous state and private partners working with the Bureau in serving the state's MCH population.

//2010//

D. Other MCH Capacity

The MCHBG supports 10.69 FTE at the state level. These FTE are all or part of 16 staff members' time. The amount of FTE supported by MCHBG and the role of the staff member are described below:

Section	Staff member	FTE Paid by	Role

		MCHBG	
CACH			
	Dennis Cox	1	Adolescent/School Health
	Deborah Henderson	0.5	CACH Section Supervisor
	Wilda McGraw	1	FICMR, Child Health
	Cindy Mitchell	0.5	Admin Support
	Cheri Seed	0.5	Oral Health
	Sandra Van Campen	0.5	PHHV/FAS Prevention
MCHDM			
	Sib Clack	0.35	NB Screening & Birth Defects
	Kindra Elgen	0.50	MCH Data Manager
	Rosina Everitte	0.17	MCH Epidemiology/Statistician
	Jack Lowney,	1.00	MCHBG & Contracts
Subtotal of CACH and MCHDM		6.02	
CSHS			
	Archambault, B.	1.00	Nurse Consultant and Acting Supervisor
	Donnelly, M.	0.80	Nurse Consultant and Data System
	Gruby, T.	0.87	Accountant
	O'Donnell, M.	1.00	Clinic Coordinator
	Scott, C.	1.00	Outreach Coordinator
Subtotal		4.67	
Total		10.69	

Jo Ann Dotson's time is cost allocated across the bureau based on staff time, incorporating some MCHBG based on 6.02 FTE. Jackie Forba's time is fully covered by CHIP.

The FCHB Bureau has a staff of 30 and the HRB a staff of 18. All other FCHB state staff and portions of the MCHBG supported staff are paid from other funding, including federal funds (WIC, Title X, Newborn Hearing Screening, SOHCS, SSDI and FAS) and a small portion of general fund. HRB staff outside of the CSHS program is supported by a combination of federal CHIP and state match.

FCHB has one federal staff person, Dianna Frick, who is responsible for coordinating the 2005 needs assessment and the subsequent MCH needs prioritization and strategic planning. Dianna's position will be in existence for two years (Sept. 2004-Sept. 2006) and is a result of FCHB's successful application for a Public Health Prevention Service fellow through the Centers for Disease Control and Prevention.

In addition to program staff, administrative costs are allocated to all programs in the state agency to support fiscal, operations and legal services. Cost allocation is budgeted based on an analysis of services costs anticipated -- for SFY 04, that estimate is for approximately 5.3% of the total budget. In addition, state law allows local health departments to use up to 10% of their funds for administrative purposes. Local agencies have been reported approximately 7.2% of their expenses as administrative costs.

As stated earlier in this application, much of the capacity to address the health needs of the MCH population exists at the local level. MCHBG is distributed to 54 of the 56 counties through MCH Contracts. Those amounts are based on an allocation formula that considers target population and poverty levels. The amount of funding obviously impacts the amount of time and subsequent work,which may be "purchased" with the dollars -- some of the smallest counties receive only $1,000. The funding does require that a designated individual be available to monitor MCH needs. According to the Montana 2004 County Health Profiles, there were approximately 124 public health nurses, 84 registered sanitarians, 14 registered dieticians and 41 health educator FTEs in public health settings across the state. The MCHBG helps support a portion of those

positions, and in cases, provides the "anchor" or designated funding for public health in the county.

The Public Health Data System (PHDS) is a system developed for local health departments to use for case management and project reporting. SSDI funding helped in the initial development phases. The system is supported with approximately $25,000 annually -- to date that amount has been matched or exceeded by various other sources, including Preventive Health Block Grant, Immunizations and Title X. While still a work in progress, the concept of common reporting software is crucial to accurate assessment and documentation of public health services. Administration of the PHDS has been transferred to the Public Health Informatics Section in the Division.The Health Resources Bureau maintains a Family Health Line Since January 2001, the Department of Public Health and Human Services' Family Health Line (1-877-KidsNow) has been the toll-free line with which Montanans can access information about health care programs for children and other health issues sponsored and promoted by the Department. Most of the calls received on the Family Health Line are related to CHIP (the Children's Health Insurance Plan), but approximately one-fourth of the nearly 12,390 phone calls received in 2004 has a referral component, in which the caller is referred to programs, both public and private, including those administered under Montana's Maternal and Child Health Block Grant. The National March of Dimes Toll Free line now provides consumer and provider call in services, with back up teratogenic counseling and assessment available. Montana continues to support the concept of a nationally supported toll free line, similar to the Poison Control Line system created approximately 25 years ago.

March of Dimes and is the Region VIII Councilor forthe Association of Maternal Child Health Programs.

/2007/ The FCHB experienced extensive staff changes during 2005-2006, due in part to retirements and family members moving out of state. Four of the bureau's five sections have new managers, including the CSHS, which was vacant for approximately 2 years. The MCHBG supports 12.25 FTE at the state level.

Employee name	Section	Role
Dennis Cox	CACH	Adolescent/Youth Suicide Prevention (vacant as of 7/31/06), currently recruiting
Deborah Henderson	CACH	Section Supervisor
Julie Chafee	CACH	FICMR, Child Health, School Health - hired in 2006
Candy Burch	CACH	Admin Support - hired in 2006
Rae Brown	CACH	PHHV, FASD Prevention - hired in 2006
Ann Hagen-Buss	MCHDM	Section Supervisor - hired in 2006
Camie Zufelt	MCHDM	Data Manager - hired in 2006
Shannon Koenig	MCHDM	Admin Support - hired in 2006
Theresa Gruby	MCHDM	Accountant & Contracts
Margaret Virag	MCHDM	Oral Health - hired in 2006
Mary Runkel	CSHS	Section Supervisor - hired in 2006
Mary Lynn Donnelly	CSHS	Nurse Consultant and Data System
Michelle O'Donnell	CSHS	Clinic Coordinator
Corliss Scott	CSHS	Admin Support and Outreach
Sib Clack	CSHS	NB Screening & Birth Defects
Shari Pettit	CSHS	Nurse Consultant
Rosina Everitte	FCHB	MCH Epidemiology/Statistician (vacant as of 7/15/06, Dianna Frick hired and will begin 9/18/06)

An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/The FCHB had limited staff changes during the last year, with most of the new staff hired in 2007 experiencing great success in their new roles. The Bureau staff is at present 39, with the MCHBG supporting 12.35 of those staff at the state level. Approximately 42% of the MCHBG also continues to be distributed through formula to 54 of the state's 56 counties, supporting the delivery of MCH services statewide.

//2008//

/2009/The MCH BG supports 11.6 of the 34 FCHB staff. A funding formula, based on the county's maternal and child health population, is used when allocating approximately 42% of MCHBG to the local public health departments. In FY 08, 53 of the 56 counties provided MCH services. CSHS continues to receive 30% of the MCH BG funding, supporting staff, Regional Pediatric Specialty Clinics, direct pay services and other activities of the section..

//2009//

/2010/

In FY 2010 the MCH Block Grant allocation will be spent as follows: 30% on children with special health care needs who receive services from one of the three Regional Pediatric Specialty Clinics or direct pay services; 21% on the salaries for the 11.6 FTE; and approximately 7% on the indirect charges which is the cost of doing business.

The lion's share of the funding will be allocated to the local county health departments. Approximately 42% will be distributed to 54 of Montana's 56 local county health departments in FY 10. It is anticipated that the locals will continue serving approximately 25% of the target population. For example: In FY 08 the locals provided MCH services to 103,326 women of child bearing age, pregnant women, infants, children, and children with special health care needs or about 24.8% of the total MCH target population. The allocation continues to comply with the federal mandated 30/30/10 requirements. //2010//

E. State Agency Coordination

Perhaps the sole benefit of the small size of the public health service community in Montana is that coordination of services becomes a relatively easy process. The fact that a few people wear many hats at both the state and local levels and in the private and not-for-profit communities usually results in more thorough coordination of the available services. Everyone knows everyone and many clients are served in common. People work diligently to meet local client needs as efficiently and effectively as scarce resources allow. Local input is sought at the state level, usually in the form of advisory councils or committees and functional work committees.

There are two Advisory Councils that advise the department on programs and services in the Family and Community Health Bureau and the Children's Special Health Services program. The Family and Community Health Bureau Advisory Council is charged with advising "… the Family and Community Health Bureau (FCHB) and the Department of Public Health and Human Services on matters impacting the Bureau's target populations, including pregnant women, women of childbearing age, infants, children to aged 22." The AC Purpose and Guidelines document and the list of 05-06 members is attached. The Council meetings every two months via TC, and advises the department in the interim via e-mail and by phone.

The Family and Community Health Bureau Advisory Council is instrumental in helping link and guide the Bureau. In Calendar 06, the Bureau will undergo a strategic planning update, facilitated

by the PHPS and informed by the needs assessment submitted in this application. The strategic planning process will include AC members, contractor representatives, program managers and staff. The FCHBAC members provided effective advocacy for MCH programs during the 2003 and 2005 State Legislature and played key roles in preserving the state's general fund support of the public health home visiting program for high-risk pregnant women and infants addressed in legislation as Montana's Initiative for the Abatement of Mortality in Infants or MIAMI.

The Children's Special Health Services (CSHS) section is located in the Health Care Resources Bureau and coordinates services and activities directly with providers through the Montana Chapter of American Academy of Pediatrics, an advisory committee, public payers such as SCHIP, state employee benefits plan and Medicaid, the Family Voices chapter housed at Parents Lets Unite for Kids (PLUK), the Insurance Commissioners Office and others. CSHS continues to expand their ability to coordinate services with other partners who work with CSHCN. In Montana much of this activity occurs at the local level through service providers. CSHS also works towards coordination at the state level. The State CHIP program is also contained in the HCRB and collaboration with Medicaid is an integral part of operations. The CSHS section receives input and guidance from an advisory group consisting primarily of medical providers, but also including parent participants and advisors. Jo Ann Dotson, the Bureau chief of the Family and Community Health Bureau participates as a staff member on the CSHS Advisory Group.

The PHSD and FCHB also have other Advisory Councils. At present, the PHSD has approximately 35 councils, many of them linked to specific grants. The FCHB has The Birth Outcome Monitoring AC, The Dental Access Coalition, the Family Planning Medical Standards Committee, Fetal Alcohol Syndrome Advisory Council, Fetal Infant & Child Mortality Review Work Group, the Newborn Hearing Screening Task Force, Newborn Screening Advisory Board, the Suicide Prevention Work Group and the WIC Steering Committee. The Governor's office is examining all ACs, and anticipating combining some of these functions into the FCHB AC structure, which will be done over the next year.

FCHB and HRCB Staff participates on several intra and interagency groups targeting the MCH population. Examples of those groups include:

Connecting for Kids -- Primarily designed as an intra agency group, this group began meeting in 2004, in order to address challenges of linking existing programs and services. Programs, including DD, foster care, and others, were facing instances in which children's insurance or other services stopped with no transition plan. This group's stated purpose is to "… look at the systems that serve children in Montana, to enhance coordination of programs, and improve communications between programs to deliver services in the most efficient manner possible".

Healthy Kids - Quarterly meetings are held with the Office of Public Instruction (which is the state's Department of Education) in order to discuss issues that cross departmental boundaries, such as dispensing medications in the schools, management of biohazards in schools and management of asthma. Dennis Cox helps facilitate that group, setting the agenda every other meeting.

Kid's Count Advisory Council -- This projects is directed by the Bureau of Business and Research of the University of Montana. Funded in Part by the Annie E. Casey Foundation, this project helps to inform health policy discussion and decisions. The project publishes and distributes a Montana specific report every year. This advisory council meetings quarterly. The department also supports the printing and distribution of the Kids' Count Book to local communities.

March of Dimes Board of Directors -- This board meets monthly. Jo Ann Dotson represents public health on this board. The Bureau shares common goals to improve pregnancy outcomes and decrease infant mortality, including that attributable to prematurity, with the March of Dimes organization.

/2007/Reorganization resulted in the move of the CSHS section to the Family and Community Health Bureau effective January 1, 2006. The CSHS Advisory Committee now functions as a subcommittee to the Family and Community Health Bureau Advisory Council. An executive order (included as an attachment) to make the FCHB Advisory Council members governor-appointed was proposed. The FCHB Advisory Council members are currently appointed by the FCHB Bureau Chief. The executive order is under review and has not yet been signed. //2007//

/2008/
As noted above, the Primary Care Office was moved to the Family and Community Health Bureau effective January 1, 2007.

The "Connecting for Kids" group has been examined over the last year. The focus on developing a system of care for children's Mental Health has emerged as a top priority, and a system of care Committee created. The Connecting work group continues to meet to deal with individual client needs, but the primary effort has shifted to the System of Care. Bonnie Adee, the former ombudsment in the Governor's Office assumed the role of Children's Mental Health Bureau Chief in 2006, and is guiding the development of a system of care statewide. FCHB staff have participated in the meetings, and will continue to monitor progress of that effort.

FCHB Managers, four of 5 whom were hired in 2006, have become valuable members of many agency and statewide organizations. Mary Runkel (CSHS Manager) was invited to participate on a Montana Academy of Pediatrics subcommittee, and participated as the state level participant in the Genetics Meeting in Denver this spring. Joan Bowsher (WIC Manager), a former county agency preparedness division leader, was asked to represent MCH on the state level Preparedness Planning Committee. Ann Hagen-Buss (MCHDM Manager) and Deborah Henderson (CACH Manager) are working with the Human and Community Services Division as they expand oral health and home visiting services and implement the Early Childhood Services project in partnership with the Early Childhood Services Bureau in that division. Colleen Lindsay (Women's and Men's Health Manager) was also asked to participate in an advisory capacity in the development of a comprehensive sexual health education proposal which may be submitted in the next legislative session. Attached is a pictorial representation of each Section's numerous partnerships formed this past year.

The Bureau's Strategic Planning process resulted in a more concentrated focus on each section's current and formation of future partnerships with governmental and private organizations who support the National and State Performance Measures and the Health Systems Capacity Indicators and goals and objectives related to other grants managed within the Bureau. //2008//

/2009/Montana is often referred to as The Treasure State, of which probably the greatest treasure is its people. It is these people, in the public and private organizations where they work, who are invaluable to the Bureau's ability in addressing the National and State Performance Measures and the Health Systems Capacity Indicators. The attached partnership charts are a pictorial representation of the numerous collaborations that have been maintained and/or initiated this past year.

The Bureau's Strategic Planning process expanded to include a more careful analysis of staff capacity to take on additional funding streams, albeit supplementing the MCH BG funds, especially in light of the fact that any additional employees must have legislative approval. At this time, the WIC and CACH Sections are leading statewide task forces charged with studying and making a recommendation(s) to the Family Health Advisory Council on the WIC and Public Health Home Visiting Programs.

In this past year, the "Connecting for Kids" group refocused attentions on individual case management for children requiring transition services, thereby limiting the FCHB role. The Early Childhood Services Systems grant was transferred to the Early Childhood Services Bureau, with the FCHB remaining involved on the project task force. //2009//

/2010/

The attached Partnership Diagrams illustrate the Bureau's numerous collaborations with state and private human services agencies across Montana. These partnerships enhance as well as support the Bureau's programs addressing the health care needs of the MCH population, which are reflective of the priority health care needs found in the 2005 Maternal and Child Health Needs Assessment report and the 2008 Family Health Advisory Council Report. These are accessible at: http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml

Included in the 2008 Family Health Advisory Council Report is Appendix B: Bureau Priorities by Major Programs Crosswalk, which is included as an attachment. Appendix B correlates with the priority areas identified by the 2005 Needs Assessment which are outlined on the Blueprint for Maternal and Child Health In Montana.

The Child, Adolescent and Community Health/CACH was renamed to the Infant, Child, and Maternal Health Section (ICMHS) because of its oversight of the public health home visiting project (PHHV) and working with communities for identifying as well as implementing prevention measures to reduce the number of preventable deaths. ICMHS staff members met regularly with the PHHV Reassessment Work Group throughout the year and developed eight health improvement priority areas that will be addressed in the coming year.

The Children with Special Health Care Needs (CSHS) Section and the ICMHS Supervisors are working with Medicaid on examining Targeted Case Management services and reimbursement rates for the Public Health Home Visiting Project and CSHS clients. Their work is expected to continue into this coming year.

A Division level decision was made to relocate the Newborn Screening Position to the Department's Laboratory Services Bureau effective July 1, 2009. CSHS will continue to provide oversight of the Newborn Screening Follow Up Program and maintain a close working relationship with the Lab.

//2010//

An attachment is included in this section.

F. Health Systems Capacity Indicators

Introduction

/2009/ Montana's ability to report data for the Health Systems Capacity Indicators continues to improve. The July 15, 2008 submission is the first time linked birth and Medicaid data have been available to report on HSCI 05. While the analysis is preliminary due to the recent acquisition of the data, the continued discussions with Medicaid and other partners related to data availability strengthen partnerships between programs and health professionals and result in greater capacity for interpretation and use of data sources for MCH programs. //2009//

/2010/ Of particular note for the 2010 application is the availability of the source of payment for birth record data. As of January 1, 2008, Montana adopted a new birth certificate format, which follows the 2003 revision of the U.S. Standard Certificate of Live Birth and includes principal source of payment for the delivery. Additional information collected on the new birth certificate includes WIC enrollment, breastfeeding at hospital discharge, and cigarette smoking by trimesters. Montana included an additional data element - alcohol use during pregnancy - that is not included on the U.S. version.

An additional change that is expected to affect some of the HSCI in future years is the passing of Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	14.9	23.1	24.9	20.1	20.1
Numerator	82	131	145	120	120
Denominator	54869	56797	58191	59581	59581
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 data are not yet available.

As of the 2008 submission, hospital discharge records are used to report the numerator for this indicator. 2005 is the first year that reflects this change in data sources. Prior to 2005 the numerator was Medicaid data. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5. The denominator is census estimates of children 0 through 4 years of age (May 2009 version).

Notes - 2007
As of the 2008 submission, hospital discharge records were used to report the numerator for this indicator. 2005 is the first year that reflects this change in data sources. Prior to 2005 the numerator was Medicaid data. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5. The denominator is census estimates of children 0 through 4 years of age (May 2009 version).

Notes - 2006
As of the 2008 submission, hospital discharge records are used to report the numerator for this indicator. 2005 is the first year that reflects this change in data sources. Prior to 2005 the numerator was Medicaid data. Reporting of hospital discharge records is not required in Montana. Not all facilities report discharge data and reporting may not be standardized. However, this source is the only statewide indication of hospitalizations for asthma among children under 5. The denominator is census estimates of children 0 through 4 years of age (May 2009 version).

An attachment is included in this section.

Narrative:

Montana does not have an ideal population-based data source for this indicator. Medicaid claims data were used as the data source prior to 2005, although the records included only represent a subset of Montana's pediatric population. Due to the way Medicaid data are collected, it was not possible to determine whether all of the hospitalizations for children diagnosed with asthma were related to asthma. The numbers prior to 2005 are not considered a good indication of the rate of asthma hospitalizations, as the data source is not population-based.

The results for this indicator have varied since 1998, and the number of children hospitalized who had asthma appeared quite low until 2005, with numbers less than 100. This is believed to be due to inadequate reporting, however, and not necessarily reflective of the true rate of hospitalizations. The rate prior to 2005 also appears low compared to HSI 01 results from other states and jurisdictions, although data sources vary so the comparability is questionable. As of 2005, hospital discharge records are used as the data source for this indicator.

As children in lower-income (and possibly Medicaid-eligible) households may be more at risk for asthma due to quality of housing, limitations in medical care and exposure to other risk factors, it was believed that the rate of hospitalizations among children with asthma enrolled in Medicaid (54.1 in 2005, 52.7 in 2006 and 64.9 in 2007), was higher than that of the general population. Due to the way Medicaid data are reported, actual hospitalizations for asthma could not be identified, only hospitalizations among children with asthma. The hospital discharge records are an indication of hospitalizations for asthma, but do not reflect records from all hospitals in the state (although all of the largest are included). Reporting of discharge data is not required in Montana, and reporting may not be standardized. IHS and VA facilities are not included, and the completeness of reporting varies from quarter to quarter and year to year. However, hospital discharge records that are available are currently considered a more complete source of data for this indicator than Medicaid.

/2010/ Although the quality of the limited hospital discharge data that are available continues to improve, a bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass. //2010//

In 2006, 145 admissions in the hospital discharge dataset were for children under 5 with a primary diagnosis code for asthma. 152 admissions for children under 5 had a secondary diagnosis code for asthma. In 2005, 131 hospitalizations for children under 5 had a primary diagnosis code for asthma and 190 had a secondary diagnosis code for asthma. In 2004, 110 admissions for children under 5 recorded a primary diagnosis code for asthma, and 122 admissions had a secondary diagnosis code for asthma.

/2010/ In 2007, 120 children under 5 years of age who were hospitalized had a primary diagnosis of asthma. 157 children under 5 had a secondary diagnosis of asthma. //2010//

Montana's Title V program does not have an asthma component, but the program does collaborate with projects related to asthma and healthy environments. Previously, Montana's Environmental Public Health Tracking (EPHT) Project is working with communities to identify the primary environmental health risks, some of which are possible risk factors for asthma. However, in 2006 the Environmental Public Health Tracking Project was not funded and the tracking activities have ceased. The 2007 Montana Legislature approved the use of general funds for asthma surveillance and control. As a result, the Chronic Disease Bureau of MT DPHHS recently initiated an asthma program and hired a coordinator. A report on the burden of asthma in Montana was released in 2007.

/2010/ A "Montana State Asthma Plan" was released in March 2009, developed by the Montana Asthma Advisory Group. The advisory group, formed in January 2008, includes over 30 individuals representing 25 agencies and organizations, including the Title V program, and works to coordinate asthma control efforts in the state. The plan describes strategies to improve surveillance systems, partnerships, and services for children with

asthma. In particular, the plan calls for legislation to require hospital discharge data reporting.

The most recent National Survey of Children's Health (NSCH), with data from 2007, did not include a question about asthma-related hospitalizations as it did in 2003. It did measure prevalence, with 6.6% of Montana children 0-17 currently having asthma, as compared to 9.0% nationally. In addition, 3.3% of Montana children had asthma in the past but not at the time of the survey, compared to 4.5% of children in the U.S.

While the NSCH data show that children in Montana have lower rates of asthma than the rest of the country, the actual prevalence of asthma in the state may be higher than reported. The survey question asked if a healthcare professional had diagnosed the child with asthma, so limited access to healthcare (an identified problem in the state) may influence the prevalence measure.
//2010//

Environmental health was identified as a priority area during the Family and Community Health Bureau's (FCHB) strategic planning activities. FCHB explores partnerships related to environmental health and possible ways to include environmental health education in existing programs.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	84.3	88.3	91.9	88.0	92.7
Numerator	4359	4635	1160	4717	5118
Denominator	5172	5249	1262	5359	5520
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
This data for FFY 2008 came from the EPSDT report from the Montana Medicaid Program on 4/22/09.

Notes - 2007
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FFY 2007. cz

Notes - 2006
This data came from the EPSDT report from the Montana Medicaid Program. It is an annual report for FFY 2006.
An updated Medicaid data were also published on March 3rd, 2009 for FFY 2006. The released data did reflect a change in the denominator previously reported as 5,106 to the updated denominator of 1262 for FFY 2006 data. This changed the Annual Indicator for FFY 2006 from 22.7 to 91.9.

An attachment is included in this section.

Narrative:

Montana's Medicaid program is in a different division of the MT Department of Public Health and Human Services than the state's Title V program. Collaboration does occur where appropriate around MCH-specific activities. For instance, the Children's Special Health Services (CSHS) section collaborated with Medicaid's Early, Periodic,
Screening, Diagnosis and Treatment (EPSDT) program to promote the awareness of the medical home concept for CSHCN. Hearing and mandated genetic screening also occur for the majority of Montana's children, regardless of whether they are Medicaid enrollees or not. Efforts to increase the percent of infants screened are ongoing through the development of new partnerships, support of current relationships and exploration of new legislation or guidelines to support screenings.

/2009/ The percentage of Medicaid-enrolled infants who receive at least one initial periodic screen has ranged from 84% - 88% over the past five years. ***/2010/ The denominator for '06 were updated by Medicaid on March 9, 2009 resulting in change in the Annual Indicator from 22.7 to 91.9 for '06. There is a almost 4 percentage point decrease in the annual objective from the year 06 to 07 following an annual objective increase by almost 5 percentage points from the year 07 to 08. /2010/ //2009// Due to the small size of Montana's population, 10 years of data might provide a more realistic indication of trend for this indicator. Changes in Medicaid policies, eligible population, access to providers, and other factors that could affect access to screenings and cause the data fluctuations are not reflected by the numbers. /2009/ The variations in the five years reflected here indicate that Montana's percent of infants screened is staying at about 85% or higher. //2009//***

The Family and Community Health Bureau submitted an application for the Targeted State MCH Oral Health Service Systems Grant Program with successful applicants to be notified by September 1, 2007. Included in this application were strategies specifically addressing how Community Health Centers could increase their numbers of EPSDT screenings. /2009/ Montana was not one of the 20 states funded with the Targeted State MCH Oral Health Service Systems Grant. //2009//

/2010/ In March 2009 the Medicaid Program updated the numbers for 2006. Changes in the data reflect a steady increase in the annual indicator, with the exception of 2007. This fluctuation in 2007 could be due to changes in Medicaid's data collection and reporting system (note the difference in numbers for 2006), or simply an unusual year. The Medicaid data source is a fairly complex one to extract data from, and the data often change over time as they are updated and cleaned. The Medicaid EPSDT benefit is optional for the medically needy population, which may also affect the participation in the services offered by the program. The Medicaid program continues to try to increase the number of enrollees who receive screenings. Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	0.0	0.0	0.0	0	0
Numerator	0	0	0		

Denominator	1	1	1		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data are not available for this indicator.

Notes - 2007
Data are not available for this indicator.

Notes - 2006
Data are not available for this indicator.

Narrative:
Montana's CHIP program does not collect data that can be used for this Health System Capacity Indicator. The data presented in HSCI02 are considered most indicative of this statistic even though children eligible for Medicaid in Montana are not eligible for CHIP. At this time MT CHIP has no plans to collect these data.

/2010/ In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. Although this change may not affect Montana's ability to report on this capacity indicator, it is expected to increase the number of children who receive health care and screenings through the CHIP program. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	81.1	80.2	78.8	78.7	59.7
Numerator	9214	9251	9818	9772	7498
Denominator	11355	11539	12462	12414	12567
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
Data for this measure for 2008 should not be compared to prior years due to changes in the way the data are collected. The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence. A new birth record format was implemented

in 2008, following the 2003 revisions to the US Standard Certificate of Live Birth. The new birth record revised the way data on prenatal care initiation are reported. Also, due to the change the number of records with unknown or missing data increased. In 2008, the percent of births with unknown timing of prenatal care was 6.5%, compared to <1% in previous years. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index.

Notes - 2007
The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence. The 2007 data were updated for the July 2009 submission with final vital statistics data.

Notes - 2006
The data source for this measure is the Montana Office of Vital Statistics. Both the numerator and the denominator reflect data on live births to Montana women 15-44 years of age, regardless of the place of occurrence.

An attachment is included in this section.

Narrative:
The data source for this indicator is birth records. Vital records data for the most recent year are still provisional at the time of the block grant submission, so the indicator may shift slightly with finalized numbers. However, the preliminary indicator is generally similar to the final.

In 2005 and 2006, the percent of women with adequate prenatal visits according to the Kotelchuck Index decreased slightly. However, over the past 5 years, Montana has seen a trend towards an increase in prenatal visits. /2009/ The indicator appears to hover near 80% //2009//.

/2010/ In 2008, Montana adopted the new birth certificate format (2003 revision of the U.S. Standard Certificate of Live Birth). 2008 data should not be compared with data from previous years due to the changes in the way the data are collected. The substantial decrease in early prenatal care initiation is believed to relate to the new birth record format and the change in the way the data are collected. Other states have experienced the same drop when the new format was implemented.

As NCHS noted in Births: Final data for 2005, "Prenatal care data based on the revised certificate present a markedly less favorable picture of prenatal care utilization than those based on the unrevised certificate. For the first year the new certificates are implemented, the percentage of women reported to begin care in the first trimester typically falls in a state by at least 10 percent. Much, if not all of this decline is clearly related to changes in reporting and not to changes in prenatal care utilization. In brief, the revised item asks for the exact "date of the first prenatal visit," and the instructions recommend that the information be collected directly from the mother's prenatal care records. The 1989 Certificate, in contrast, includes the less specific "month of pregnancy prenatal care began" (e.g., 1st, 2nd, 3rd), and no source for these data is recommended. "
From: Martin JA, Hamilton BE, Sutton PD, Ventura SJ, Menacker F, Kirmeyer S, Munson ML. Births: Final data for 2005. National vital statistics reports; vol 56 no 6. Hyattsville, MD: National Center for Health Statistics. 2007.

Also, 6% of 2008 records have "unknown" timing of prenatal care initiation, a large increase from the approximately 2% reported in previous years. This is expected to improve in subsequent years as hospitals and staff become more familiar with the new birth certificate format. Among births with known prenatal care, 63.8% were less than or equal to 80% on the Kotelchuck Index. More complete data in subsequent years will indicate whether the unknowns resulted in an underestimate of the actual number of women with adequate prenatal care. //2010//

The American Hospital Association Data reported a decline in the number of hospitals throughout the state providing obstetrical care, from 34 in 2004 to 32 in 2005. This number does not include Indian Health Services (IHS) facilities, and so is not a complete representation of delivery sites. However, it may indicate some limitations on where pregnant women can access prenatal and obstetric services.

Several programs coordinated through Montana's Family and Community Health Bureau (FCHB), the State's Title V program, contribute to education on and support for prenatal care. The Public Health Home Visiting (PHHV) program provides home visits to at-risk pregnant women. WIC offers nutrition education and resources. The Fetal, Infant and Child Mortality Review (FICMR) offers information on preventing premature births. As these programs have expanded and become more visible and known in communities over the past several years, the messages on prenatal care are reaching more and more women. Where possible, programs such as WIC are also connecting women with sources of prenatal care, such as Medicaid or private providers. County Health Departments that receive Title V funds (54 of 56 counties) also provide services on a sliding fee scale.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	88.7	88.7	86.1	97.7	94.4
Numerator	57700	58602	51200	59989	59261
Denominator	65079	66078	59448	61393	62801
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
The numerator and denominator were obtained from Medicaid Program. The data were pulled on April 15, 2009 from MMIS the Medicaid database using a Query Path.
The data include any child that was eligible for Medicaid during any part of the fiscal year and was 18 or under at the start of the fiscal year.

There is a large increase in the annual indicator for 2007 and 2008 compared to previous years. Prior to 2007 the Current Population Survey (CPS) Table Creator II data was used as a source for the denominator. Most recently Medicaid data became available for potentially Medicaid-eligible children who received services paid by the Medicaid Program. The Medicaid data illustrates higher numbers than the CPS table reflects. The variation in the numbers between Medicaid and CPS data illustrate that the numbers given by the US Census estimates underestimate the numbers of children eligible and how many children can by served by Medicaid in Montana.

Notes - 2007
The numerator and denominator were obtained from Medicaid Program. The data were pulled on July 10, 2009 from MMIS the Medicaid database using a Query Path.
The data include any child that was eligible for Medicaid during any part of the fiscal year and

was 18 or under at the start of the fiscal year.

Providers have up to a year from the last date of service to bill Medicaid with 9/30/2008 being the last date Medicaid would pay any claims for FFY2007.

Notes - 2006
This data came from the Montana Medicaid Program. It was pulled from MMIS the medicaid database using a querying system called QueryPath.

An attachment is included in this section.

Narrative:
These data come from the Montana Medicaid Program's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) report. The percent of eligible children who have received a Medicaid paid service has remained fairly steady over the past several years, although the number dropped slightly in 2006. The reason for the drop is unknown.

Montana's Maternal and Child Health program has limited influence over Medicaid-provided programs. Several MCH programs collaborate with Medicaid to try to increase care or educate Medicaid providers and program staff on possible services and interventions. For instance, the WIC and Children's Special Health Service (CSHS) programs both assist their clients to verify whether they are eligible and initiate enrollment in Medicaid where appropriate. CSHS, the Child, Adolescent and Community Health (CACH) section and the Oral Health Education Specialist have all developed relationships with Medicaid to collaborate on programs that will help serve children and facilitate their access to Medicaid services.

Montana struggles with access to providers, particularly providers who will accept Medicaid, which certainly affects this indicator. As populations within the state shift towards larger population centers, rural areas are having more difficulty recruiting and keeping providers. Transportation challenges and distances involved in getting to a health provider can deter families from using services. In some of the state's population centers, providers are over-booked and it may be a challenge to find a physician accepting new patients or Medicaid-eligible clients.

/2010/ The same data source was used for 2008 as for previous years. The numbers of participants who received a service paid by the Medicaid Program steadily increased until 2006. In 2006 there was a slight drop in the Medicaid-paid services, but the numbers increased again in 2007 and 2008. The increase noted in the last couple of years might be influenced by better reporting, as well as a revision in the family asset test used in determining children's Medicaid eligibility that was implemented in 2006. Reimbursement rates for Medicaid providers were also increased in 2007 and 2008 with the intent of improving access to services for Medicaid participants. Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	32.9	34.3	33.4	39.7	52.2
Numerator	3931	4182	4099	4897	6406
Denominator	11960	12182	12279	12320	12269
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
This data came on 4/22/09 from the EPSDT report from the Montana Medicaid Program for the FFY 2008.

Notes - 2007
This data came from the EPSDT report from the Montana Medicaid Program. It is annual report for the FFY 2007.

Notes - 2006
This data came from the EPSDT report from the Montana Medicaid Program. It is annual report for the FFY 2006.
An updated Medicaid data were also published on March 3rd, 2009 for FFY '06 & '07. The released data did reflect a change for FFY 2006 data in the denominator previously reported as 12,182 to the updated denominator of 12,279. The updated numbers changed the Annual Indicator for FFY 2006 from 33.6 to 33.4.

An attachment is included in this section.

Narrative:
The percent of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible children who have received dental services during the year has remained fairly steady and lowover the past five years, never above 35%.

Montana's maternal and child health (MCH) program has limited ability to affect Medicaid programs. However, the Oral Health Education Specialist (within the MCH program) continues to collaborate with Medicaid on dental access issues.

Montana struggles with a shortage of dental professionals in the state. The shortage is even more severe in rural areas and when considering dentists who accept Medicaid and child clients. For children with behavioral problems or special needs, finding a dentist who will accept them as a client can be even more challenging. There were 361 dentists and denturists in Montana who accepted Medicaid clients during state fiscal year 2005 (7/1/04 to 6/30/05) and 332 in state fiscal year 2006 (7/1/05 to 6/30/06), a decline of 29 in a one-year period. As of December 31, 2005, CHIP had 269 dentists practicing in 279 locations, leaving 14 Montana counties (25%) with no CHIP enrolled dentist. As of December 31, 2006, there were 252 dentists treating CHIP-eligible children. According to the Montana Primary Care Office, 37 of Montana's 56 counties are designated as Dental Health Professional Shortage Areas

/2010/ The number of EPSDT-eligible children 6-9 years old who received dental services increased substantially in the past couple of years. The increase in dental services in 2008 could be related an increase in Medicaid dental provider rates that went into effect in October of 2007. Dental provider rates were increased from 64% of charges for children to 85% of charges in the aggregate. Montana continues to experience shortages in dental health professionals overall, and particularly in health professionals who serve Medicaid

clients.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.0	1.1	0.0	0.0	0.0
Numerator	18	22	0	0	0
Denominator	1892	1957	1	1	1
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
According to Montana State statute, children who receive SSI benefits automatically receive Medicaid benefits. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

Notes - 2007
In 2007, 1929 children under 16 in Montana were receiving SSI payments. According to Montana state statute, children who receive SSI benefits automatically receive Medicaid. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid. According to the block grant guidance, the goal of this indicator is "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is not provided by Medicaid." Due to the fact that Montana has met this goal, we have no data to report for this indicator.

Notes - 2006
According to Montana state statute, children who receive SSI benefits automatically receive Medicaid. Therefore, there are no children who receive SSI benefits and receive services through the children with special health care needs program whose services are not paid by Medicaid.

An attachment is included in this section.

Narrative:
During a review of the guidance for this indicator, and discussions with the Montana Children's Special Health Services Program, it was determined that no children meet the criteria to be reported in the numerator for HSCI 8. The guidance states the goal of this HSCI as "for the state CSHCN program to provide rehabilitative services for blind and disabled children less than 16 years old receiving benefits under Title SVI, to the extent medical assistance for such services is

not provided by Medicaid." In Montana, all children eligible for SSI are also eligible for Medicaid. ***/2010/ In 2006, 2007, and 2008, no SSI beneficiaries under 16 in Montana received services through the CSHCN program that were not paid for by the Medicaid program. //2010//***

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2008	payment source from birth certificate	8.6	6.7	7.4

Notes - 2010
This measure includes live births to Montana residents reported to the MT Office of Vital Statistics. The 2003 revisions of the U.S. standard certificate of live birth were adopted in MT in 2008. 9.9% of births had unknown source of payment for delivery.

Narrative:
Vital statistics records do not currently capture payment source related to birth records. The data presented above do not actually represent the percent of low birth weight in the Medicaid and non-Medicaid populations. At the time of the block grant submission, discussions were underway about whether low birth weight data were available through Medicaid. Because low birth weight is collected as a risk code and not as a part of claims data, there were some doubts about the accurateness of using the risk code to determine the percent of Medicaid births that were low birth weight. Preliminary results indicated that there were approximately 4346 births covered by Medicaid during 2006, and 72 births that had some sort of low birth weight coding, which would result in 1.7% low birth weight. These preliminary data indicate that Medicaid paid for 35% of the births, and those births accounted for only 8% of the low birth weight infants. Because of the known limitations with how the low birth weight Medicaid data are collected, and because the preliminary percent of low birth weight is so low for the Medicaid population, this was determined not to be an accurate representation of low birth weight among Medicaid-paid births. At the time of block grant submission, Medicaid staff were running a more detailed report on the available data to determine what could be gleaned from Medicaid records.

A new birth certificate will be implemented in 2008 that collects payment source for births. For detail on low birth weight-related activities in Montana, please see the narrative for State Performance Measure 8.

/2009/ Montana's MCH program gained access to birth records linked to some Medicaid data for the first time in 2008. Previously, the state had been unable to report on this indicator, as Medicaid data on deliveries was of questionable reliability. The data indicate a substantial difference in low birth weight between Medicaid and non-Medicaid populations. The analysis is preliminary at this point due to very recent access to the data. The state's ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

/2010/ As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The

source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid.

The overall rate of low birth weight in 2008 is 7.4%. The low birth weight rate among Medicaid-paid births is 8.6%. Among the non Medicaid-paid births, the rate is 6.7%. However, if the births with an unknown payer source are excluded from the non Medicaid group, the low birth weight rate drops to 6.3%. Among births with an unknown payer source, the low birth weight rate was 10.5%. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2008	other	1	1	1

Notes - 2010
These data are not yet available. 2008 was the first year when payment source was available on the birth records. Linked birth-death-Medicaid files have suggested the rate of infant death among Medicaid-paid births is significantly higher than among non-Medicaid births. However, due to the inability to verify some of the required information, the linked data files are not used as a source for this measure Linked birth-death records using the new birth record format are expected to be available in 2010.

Narrative:
Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. The Montana Office of Vital Statistics recently linked infant birth and deaths records, which may provide a data source for this measure when data from the new birth certificate are available. Infant death data may also be available through Medicaid claims data. New Medicaid staff are working with Bureau staff to identify Medicaid data that could be used to report on block grant indicators. Data were not available at the time of the block grant submission.

Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

/2009/ A request was submitted to Medicaid to identify infants who were enrolled in Medicaid at or around the time of their deaths. Although linked birth-death records are available, Medicaid data for those infants was not available at the time of the block grant reporting. The state's possible future ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

/2010/ As of 2008, Montana collects primary source of payment as a part of the live birth record. In 2008, 30% of births were paid by Medicaid. Linked birth-death records using the new birth record format are expected to be available in 2010.

Linked birth-death-Medicaid files have suggested the rate of infant death among Medicaid-paid births is significantly higher than among non-Medicaid births. However, due to the inability to verify some of the required information, the linked data files are not used as a source for this measure.
//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	payment source from birth certificate	65.7	73.7	71.3

Notes - 2010
This measure includes live births to Montana residents reported to the MT Office of Vital Statistics. The 2003 revisions of the U.S. standard certificate of live birth were adopted in MT in 2008. As a result, the way timing of prenatal care initiation was calculated changed in 2008 and is not be comparable to previous years. In 2008, 9.9% of births had unknown source of payment for delivery and month prenatal care began was unknown for 6.1% of births (an increase from previous years).

Narrative:
Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

/2009/ Montana's MCH program gained access to birth records linked to some Medicaid data for the first time in 2008. Previously, the state had been unable to report on this indicator, as Medicaid data on deliveries was of questionable reliability. The data indicate a substantial difference in initiation of prenatal care between Medicaid and non-Medicaid populations. The analysis is preliminary at this point due to very recent access to the data. The state's ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

/2010/ As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. The source of payment was unknown for 10% of the births. Some of these births were likely paid for by Medicaid.

Overall, 71.3% of women who gave birth in 2008 began prenatal care in the first trimester. Among Medicaid-paid births, 65.7% of women started prenatal care in the first trimester. Among the non Medicaid-paid births, the rate is 73.7%. However, if the births with an

unknown payer source are excluded from the non Medicaid group, the percent of women who started prenatal care in the first trimester increases to 78.9%. Among births with an unknown payer source, only 42.5% started prenatal care in the first trimester, however, timing of prenatal care initiation was unknown for 40.1% of the births with an unknown payor source. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	payment source from birth certificate	55.7	61.4	59.7

Notes - 2010
This measure includes live births to Montana residents 15-44 years of age. The 2003 revisions of the U.S. standard certificate of live birth were adopted in MT in 2008. As a result, the way timing of prenatal care initiation was calculated changed in 2008 and is not be comparable to previous years. In 2008, 9.9% of reported births had unknown source of payment for delivery and 6.5% of births had unknown adequacy of prenatal care (higher than in previous years).

Narrative:
Vital statistics records do not currently capture payment source for birth records. A new birth certificate will be implemented in 2008 that collects payment source for births. Because the percentages reported here are not based on actual data on infants covered by Medicaid, no interpretation can be made.

/2009/ Montana's MCH program gained access to birth records linked to some Medicaid data for the first time in 2008. Previously, the state had been unable to report on this indicator, as Medicaid data on deliveries was of questionable reliability. The data indicate a substantial difference in the adequacy of prenatal care between Medicaid and non-Medicaid populations. The analysis is preliminary at this point due to very recent access to the data. The state's ability to access and report these data is directly linked to the State Systems Development Initiative (SSDI) and HSCI 9A, which relates to the ability to access relevant information, as SSDI funds the bulk of the MCH Epidemiology capacity for the state. //2009//

/2010/
As of 2008, Montana collects primary source of payment as a part of the live birth record. 30% of 2008 births were paid by Medicaid. However, due to the change in the birth record format in 2008, more birth records than usual had incomplete data, partially because some out-of-state births do not collect source of payment for delivery. Overall, 6.5% of births had unknown adequacy of prenatal care. The source of payment was unknown for 10% of

the births. Some of these births were likely paid for by Medicaid.

Overall, 59.7% of women 15-44 years of age who gave birth in 2008 had adequate prenatal care. Among Medicaid-paid births, 55.7% of women had adequate prenatal care. Among the non Medicaid-paid births, 61.4% had adequate prenatal care. However, if the births with an unknown payer source are excluded from the non Medicaid group, the percent of women with adequate prenatal care increases to 66.1%. Among births with an unknown payer source, only 32.7% reported adequate prenatal care and 38.1% had unknown prenatal care adequacy. The data on payer source is expected to be more complete in future years, which will provide a more accurate picture of the differences in rates by payer source.
//2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	133
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	175

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region. However, effective July 1, 2007 the income guidelines for CHIP were changed from 150% to 175% of FPL ($36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. The anticipated impact is for an additional 2,100 children to be enrolled in CHIP, for a total enrollment of approximately 16,000 children.

/2010/Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

According to the Montana Medicaid Program, infants (0-1 year) who are deemed needy newborns (meaning that their mother was receiving categorically needy Medicaid at the time of their birth) are now (due to changes effective April 1, 2009) eligible for Medicaid with no income or resource limit for the first year of their life. Prior to the changes, the income limit was 150% FPL (as that is the income limit for pregnant women). Infants who are not deemed needy newborns (their mother was not receiving Medicaid at time of birth) have an income limit of 133% FPL.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2008	 133 100
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 18) (Age range to) (Age range to)	2008	 175

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid in Montana is lower than in other states nationwide (according to TVIS data for 2004) for infants, but similar to other states in the region. For CHIP, a comparison of Montana's poverty level-related eligibility for infants shows that it is lower than the majority of other states nationwide and within the region. However, effective July 1, 2007 the income guidelines for CHIP were changed from 150% to 175% of FPL ($36,138 for a family of four). CHIP also received funding to establish a program for CHIP children with high cost dental needs. The anticipated impact is for an additional 2,100 children to be enrolled in CHIP, for a total enrollment of approximately 16,000 children.

/2010/Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients.

Most Medicaid programs only cover children through the month of their 19th birthday. A few programs cover children through the month of the 21st birthday, but this is a very small population.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. //2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	150
INDICATOR #06	**YEAR**	**PERCENT OF**

The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.		POVERTY LEVEL SCHIP
Pregnant Women		

Notes - 2010
Montana's SCHIP (CHIP) does not cover pregnant women unless they are under 18 years of age (covered unber CHIP as children).

Narrative:
These data come from the state CHIP and Medicaid programs. The poverty level-related eligibility for Medicaid is lower than most other states (according to TVIS data for 2004) for pregnant women, but the same as other states in the region. Montana's CHIP program does not cover pregnant women over 18 years of age.

/2010/Montana continues to experience shortages in health professionals overall, and particularly in health professionals who serve Medicaid clients. In 2007, the Medicaid eligibility level for pregnant women was increased from 133% to 150% of the poverty level.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. However, no provision for increased coverage of pregnant women was included in the bill or legislation. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	1	No
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey	2	Yes

for at least 90% of in-State discharges		
Annual birth defects surveillance system	1	Yes
Survey of recent mothers at least every two years (like PRAMS)	1	Yes

Notes - 2010

Narrative:
The Family and Community Health Bureau (FCHB), Montana's Title V Program, does not have purview over the majority of the databases and surveys mentioned, with the exception of WIC, PRAMS, newborn screening, and the birth defects surveillance system. Therefore, while the Bureau is often involved in discussions regarding vital statistics data and linkages, it may not be the decision-maker.

Montana's Office of Vital Statistics recently linked infant birth and death records for a limited time period. They are moving towards linked birth and death records for a broader time period and population, but no estimated completion date has been set. /2009/ Linked birth and death records are now available for 1988-2007. //2009// ***/2010/ Birth and death record files are linked annually when the datasets are finalized. //2010//***

FCHB does have access to de-identified birth records and the death records for 1989-2005, but these files are not linked. FCHB has access to Medicaid claims files through a staff member trained in Query Path, the Medicaid data system, and by submitting requests to Medicaid staff. Medicaid claims data are not linked to birth records. Some small studies have been undertaken in MT DPHHS to link Medicaid claims data with vital records. A similar activity is planned by FCHB as a part of the SSDI grant for the 12/1/07-11/30-08 budget period. This activity will help to determine the feasibility of linking Medicaid and birth records for specific analyses, and possibly on a more ongoing basis. /2009/ Live birth records linked with some Medicaid enrollment data were available to the MCH program for the first time in early summer 2008. Additional data is expected to be available on an ongoing basis, although the extent and timeliness of the available data has not yet been determined. //2009//

The WIC data system is expected to undergo an upgrade over the next several years. The current system is somewhat unwieldy and is not linked to birth certificates. FCHB does have access to WIC data, but not linked WIC-birth certificate data. /2009/ With the hiring of a new MCH Epidemiologist in summer of 2008, the MCH epidemiology unit will be able to explore collecting some WIC participation data in a format that will facilitate linking it with birth record data. The feasibility of the data storage and linkage will be investigated in late 2008 and into 2009. //2009// ***/2010/ The new WIC data system will be implemented in early 2010, which will facilitate the linking of files. //2010//***

Efforts to link birth certificates and newborn screening data are currently underway. A linkage is available to some extent, but links for the reporting year are sometimes not available in time for block grant submission. The Newborn Screening Coordinator in the Children's Special Health Services Section of FCHB is coordinating the effort. ***/2010/ The newborn screening system is being updated to accommodate the changes in the birth record format for 2008 births and allow for linking of records. //2010//***

Some hospital discharge data for 2000-2005 were obtained by the Public Health and Safety Division in 2007. The data are expected to be available in future years, pending negotiations with the Montana Hospital Association. /2009/ The hospital discharge data available in Montana is a unique and valuable data source with some limited use to the MCH program. IHS and VA

facilities do not report, and reporting by facilities varies by quarter and year. In addition, the reporting is not standardized or required, and not all relevant data are collected. However, it collects some data that are not available through other sources. //2009// ***/2010/ A bill introduced in the 2009 legislature to require hospital reporting of discharge data did not pass. //2010//***

Montana has birth defects surveillance data through 2005. Active collection of birth defects data was suspended in 2005 when the newborn screening grant application to CDC was approved but unfunded. Discussions continue regarding possible future methods of collecting and using birth defects data. All of the data collected thus far are maintained by FCHB.

Montana received a PRAMS grant for a Point-in-Time survey in 2002. The funding application for a PRAMS grant in 2006 was not successful. The 2002 data are maintained by FCHB. At this time, FCHB is unable to conduct an independent PRAMS-like survey due to funding and staff limitations. However, possible additional and alternative data sources continue to be explored. MCH data capacity development was identified as a Bureau priority during strategic planning.

The Montana Assessment project was initiated in late 2006 to review the data systems of the Public Health and Safety Division (including the MCH data systems) and determine an inclusive process for future review and revision of public health data systems. The project will be completed in 2007 with recommendations for a data review process. /2009/ A Public Health Home Visiting (PHHV) reassessment project was initiated in 2008. //2009//

In May of 2007, the Family and Community Health Bureau MCH Epi Unit conducted an assessment and planning project for epi activities. Roger Rochat, an MCH Epidemiologist at Emory University, and the FCHB MCH Epidemiologist conducted interviews with Bureau staff and partners to identify priority MCH epi activities, including data linkages and analyses.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2010

Narrative:
Montana's Office of Public Instruction (OPI) conducts and maintains the data from the Youth Risk Behavior Survey. While the raw data are not available to the Title V program, the results of the survey are distributed in published form, and are also easily searchable and obtainable from the OPI website or the national YRBS website. The YRBS has been conducted in Montana every other year since 1993, with the most recent results available for 2007. Montana's Title V program frequently uses YRBS data for grant applications and reports, and it was a valuable source of information for the five-year maternal and child health needs assessment.

/2010/ As of 2008, the raw YRBS data are now available to the MCH program. 2007 is the most recent year available. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

Montana's maternal and child health needs assessment process is continuous. Data are collected and analyzed throughout the five-year period. The needs assessment document is an opportunity to compile data and reflect on the complete picture of MCH needs and programs in Montana. Following the submission of the 2005 MCH needs assessment, and using the assessment as a guide, Montana's Family and Community Health Bureau (FCHB) will begin a strategic planning process to further prioritize MCH needs and identify how the FCHB can address them. The strategic planning process will continue the assessment process and ensure the use of previously collected assessment data. In addition, questions were included on the stakeholder survey sent to providers regarding how the process could be useful to them. The needs assessment results will be distributed to stakeholders around the state and available on the state website, which will help to generate interest in the process and encourage use of the needs assessment results. Finally, counties receiving MCH block grant funds are required to conduct their own needs assessments every five years, and those results are incorporated into the state's data collection process.

Beginning in 2002, meetings were held at the state level to determine how the state would develop the needs assessment. The Family and Community Health Bureau within the Montana Department of Health and Human Services submitted applications for two student interns in 2003. The students were responsible for conducting key informant interviews with stakeholders throughout the state and updating data from the 2000 needs assessment during June-August of 2004. FCHB also submitted an application for a Centers for Disease Control and Prevention Public Health Prevention Specialist to be assigned to Montana to assess the needs of the MCH populations. The prevention specialist arrived in Montana at the end of August, 2004.

Two groups at the state-level were primarily responsible for shaping and directing the needs assessment process: the Family and Community Health Bureau Advisory Council (FCHB AC) and the Family and Community Health Bureau Managers. The FCHB AC includes representatives from partner organizations throughout the state, including the March of Dimes, local health officers, WIC, family planning, education, urban and rural local health departments, Indian Health Services, nurses associations, and providers. The Council was involved in determining the approach and the final format of the needs assessment survey, as well as reviewing the final document. The FCHB AC will also be an integral part of the strategic planning process and the ongoing prioritization of maternal and child health needs and activities.

The Family and Community Health Bureau Mangers is comprised of the chief of the Family and Community Health Bureau and the managers of the four sections of the Family and Community Health Bureau: Maternal and Child Health and Data Monitoring; Child, Adolescent and Community Health; Women's and Men's Health; and, Women Infants and Children (WIC)/Nutrition. The managers decided the approach and focus of the community participation component of the needs assessment, participated in the development of the surveys, and reviewed and advised on the content of the final needs assessment document.

/2008/ This past year the five sections continued to update the section workplans, which are based on the goals and objectives outlined in the FCHB strategic plan. Each section's workplan includes their specific action steps for achieving the goals and objectives outlined in the FCHB Strategic Plan. The FCHB strategic plan was in turn based on the results of the statewide 2005 MCH Needs Assessment. Each section conducts periodic reviews of their workplan and updates their progress in achieving the activities related to the eight priority areas. The FCHB Section Managers and the Bureau Chief have begun discussions on planning for the 2010 Needs Assessment. It is anticipated that the Governor-appointed Family Health Advisory Council, formerly the FCHB Advisory Council, will be actively involved in the 2010 Needs Assessment process. //2008//

/2009/ Needs assessment development continues this year on several fronts. The Bureau strategic plan has been examined and aligned with the Division strategic plan; section workplans enhanced and updated. Each section continues to conduct periodic reviews of their workplan and updates their progress accordingly. A Graduate Student Inten Program (GSIP) assignee from MCHB is working on a statewide needs assessment planning survey during the summer of 2008, and staff are planning to participate in a Rocky Mountain Public Health Education Consortium training in September, as well as a training at the MCH Epidemiology conference in December. The FH AC is meeting in August to develop a report and recommendations for the Governor per executive order. //2009//

/2010/

To continue to operationalize and build on the 2005 Needs Assessment and plan for the 2010 Needs Assessment, a Needs Assessment Team, composed of FCHB staff and partner representatives was formed. A Work Plan was developed to ensure that the 2010 Needs Assessment includes enhanced public input, greater partner involvement at the state and county level, and a systematic approach to identifying problems and possible solutions. The Team meets and updates the Work Plan weekly. The Work Plan includes information done by the 2008 GSIP and from the September 2008, Rocky Mountain Public Health Education Consortium and the December 2008, MCH Epidemiology Conferences.

The FCHB 2009 Graduate Student Intern Program assignee completed a web-based survey assessing statewide resources for the MCH population. The survey requested information about data capacity and ways to improve data usage at the local level, as well as the contact information for their county level partners. The Team will be using this information for gathering from them, as well as from established partners, reports or other references about the health of our mutual MCH target population.

The 2005 Needs Assessment remains as the foundational reference for the Bureau's maternal and child health strategic plan, as illustrated in the document entitled: Blueprint for Maternal and Child Health in Montana. This document has been discussed at the Governor appointed Family Health Advisory Council (FHAC) quarterly meetings, with attention being focused on the current State Performance Measures. In October, 2009 the FHAC and FCHB begin the discussion on selecting new State Performance Measures based on preliminary results from the Needs Assessment Team.

In the coming months, the FHAC and the Bureau will continue these discussions and will solicit input from the Bureau's public and private partners as to the proposed new state performance measures. The new state performance measures will be finalized in the spring of 2010 and the Blueprint will be revised to reflect such and submitted with the 2010 MCH Needs Assessment Report.

Attached are trend analysis charts for the National and State Performance Measures.

//2010//

An attachment is included in this section.

B. State Priorities

Selection and prioritization of state needs is an ongoing process requiring assessment of health status and system functioning indicators as well as availability of financial and human resources. Changing expectations of public health impacts the priority selection. The evolution of public health in Montana and the nation continue, moving from what was essentially individually-based services, often providing primary care or a proxy for primary care services towards a system that

is population-based, including needs assessment, policy development and assurance. Fiscal and human resource challenges affect every state, but are perhaps more distinct or apparent in communities where the rural/frontier nature and sparse distribution of clients and providers place multiple demands upon a very fragile public health infrastructure.

The following list of priority needs was generated based on a statewide survey of consumers and those caring for infants, children and families. A copy of the consumer and professional survey is attached to this section. The survey was distributed to WIC and Head Start clients, WIC and Head Start program staff and primary care and public health providers.

This survey provided public input into the development of a list of priority needs, which was further assessed based on the following criteria:

· Existence of data supporting the need
· Evidence that the MCH population, including infants, children, adolescents, children with special health care needs, women of childbearing age and their families were the target audience of the priority.
· Availability of resources and capacity within the public health system (not necessarily the MCH agency) to help address the issue.

This priority list will be the basis of the strategic planning process, which will involve the FCHB Advisory Council, the FCHB staff and local partners and consumers during FFY 06. The needs assessment will inform participants in the strategic planning process. It is anticipated that further prioritization will take place during the strategic planning process, and that the priority list will continue to change and evolve as new data, which will be part of the ongoing needs assessment, is revealed.

This list does not address overarching issues, which impact every one of the priorities. The issues include:

· The importance of a functioning public health system -- the public health system addresses the core functions of public health including assessment, policy development and assurance through the essential services. Included in those services are the responsibility to have appropriate training of public health professionals and partners, epidemiological capacity with which to analyze information regarding the population, and excellent networking among traditional and non-traditional public health providers.
· Recognition of disparity and its impact on the health of the MCH population. -- Examples include disparity in the efforts to promote the health of females in society, as well as disparity between ethnic groups, age groups (i.e. school-aged children) and urban and non-urban dwellers. Recognition of, and efforts to address these disparities is an overriding concern, as they impact all MCH priorities.

Priority Issues

1. Increase access to health care for MCH populations, including children with special health care needs.
2. Increase insurance coverage of MCH populations.
3. Promote and improve oral health services for MCH populations.
4. Reduce the rate of intentional injuries in MCH populations, including, but not limited to the incidence of domestic violence and youth suicide.
5. Promote and support families to raise children in safe and nurturing environments.
6. Reduce the rates of preventable illness in children and adolescents, including obesity and vaccine preventable illnesses.
7. Prevent substance use in MCH populations.
8. Promote access to mental health services for MCH populations.
9. Promote efforts to continue to decrease the incidence of unintended pregnancies.

Efforts to update and re-examine priorities are done annually, in the form of pre-contract surveys to all contract counties. The surveys are distributed in February of each year, and elicit county responses on topics such as the priority needs impacting the MCH target populations. The Family and Community Health Bureau Advisory Council receives and reviews summaries of the annual pre-contract surveys. Staff also has the responsibility to monitor data and available statistics.

/2007/
For the 2007 MCH Block Grant (MCHBG) submission, Montana adjusted the state's priorities to reflect the priority areas in the newly-developed Family and Community Health Bureau (FCHB) strategic plan. FCHB is Montana's Title V program. The revised list of FCHB priorities is below (please note that the priorities are not ranked). Underneath each priority is a list of any related state and national performance measure(s). The new priority areas are based on discussions and strategic planning activities, and are an evolution from last year's priorities, which were in turn based on the 5-year MCH needs assessment. The priorities listed in this year's MCHBG application are expected to stay the same for the next 5 years, although periodic reviews of the strategic plan may result in some revised and updated priority areas. A discussion of the strategic planning process and the development of this year's priorities follows the list of priority areas.

State Priorities
1) Environmental health
Montana expects to develop a state performance measure related to environmental health in the future. A new project called Healthy Air Daycare, which assesses the environmental health of daycares as a part of licensing visits, has recently been implemented and data are expected to be available within the next year.

2) Family support and education
NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16
SPM 1 (unintended pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

3) Mental health and substance abuse
NPM 8, NPM 15, NPM 16
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 6 (abstaining from cigarette smoking during pregnancy)

4) Nutrition and obesity prevention
NPM 11, NPM 14

5) Promotion of preventive and accessible health care
NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17, NPM 18
SPM 5 (Medicaid-eligible children who receive dental services)

6) Reproductive and sexual health
NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)

7) Unintentional injuries
NPM 10
SPM 4 (fetal, infant and child deaths reviewed for preventability)

SPM 7 (firearm deaths among youth aged 5-19)

8) Family and Community Health Bureau capacity development
FCHB capacity development relates to all of the performance measures. Increased staff capacity in data management, organizational relationships and management skills will contribute to their work in all MCH areas.

Strategic Planning Process
Subsequent to the completion of Montana's five-year MCH Needs Assessment in 2005, FCHB began to develop a five-year strategic plan. Two large stakeholder meetings were held in late 2005. The meeting participants included FCHB staff, FCHB Advisory Council Members, Children's Special Health Service (CSHS) Advisory Council members, and other Department of Public Health and Human Services (DPHHS) partners in MCH activities.

The first meeting, in October, established the drafts of the vision, mission, guiding principles and priority areas. The priority areas were based on the results of the statewide MCH needs assessment. Following the meeting, a small workgroup was formed for each of the priority areas, and the workgroup members developed goals and objectives related to each area.

The second large stakeholder meeting, in December, used the CAST-5 tool to identify and discuss FCHB capacity needs. Holly Grason, of Johns Hopkins University, was the facilitator. The following capacity needs were identified as priorities:

Data Capacity:
- Adequate data infrastructure (access to more and better data/strategic use of data)
- More capabilities related to translation and communication of data
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis

Organizational Relationships:
- Improved collaborative working partnerships with state and local health programs
- Expanded relationships with additional stakeholders, policy makers, advocacy groups, funders, and the business sector

Skills:
- Staff with basic data skills in all units/programs of FCHB, and additional staff with advanced skills in data analysis
- Enhanced management and organizational development skills among staff

Three small workgroups, one for each capacity need topic area, were formed to brainstorm current activities and desired activities related to each capacity need. The brainstormed ideas were then turned into goals and objectives. To include the capacity needs in the strategic plan, an eighth priority area was developed.

The most recent version of the strategic plan is attached to this section. Next to each priority area is a description of the scope of activities that fall under that area and the goals and objectives developed thus far. Please note that the strategic plan is still in draft form and not all sections are complete. Many of the objectives are still being revised so that they fit into the SMART format. The plan is currently being reviewed within each of the FCHB sections to ensure that all ongoing, planned and appropriate desired activities have been included and that the plan is still relevant given recent staff turnover and alterations in projects. The FCHB staff position(s) responsible for each objective and for the ongoing evaluation of that objective will also be determined in the section meetings or larger Bureau meetings. FCHB anticipates finalizing the strategic plan in the Fall of 2006, with periodic reviews and updates to occur after that point. //2007//

/2008/ The most current version of the strategic plan is attached to this section. The strategic

plan continues to be a working document assisting the FCHB in addressing the priority needs as identified with the 2005 Needs Assessment. The sections within FCHB have developed workplans based on the priorities, goals and objectives outlined in the Bureau strategic plan. The priority needs, which remained the same as in 2007, are as follows:

1) Environmental Health: It was determined that the Healthy Air Daycare data was not of a quality that could readily be adapted to creating a state performance measure. The Bureau's Oral Health Program is planning to strengthen their partnership with the Department of Environmental Quality with a goal of educating communities on their fluoride levels as a leveraging tool for increasing the numbers of schools participating in the fluoride mouth rinse program.

2) Family support and education
NPM 2, NPM 3, NPM 5, NPM 6, NPM 8, NPM 10, NPM 11, NPM 15, NPM 16
SPM 1 (unintended pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

3) Mental health and substance abuse
NPM 8, NPM 15, NPM 16
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 6 (abstaining from cigarette smoking during pregnancy)

4) Nutrition and obesity prevention
NPM 11, NPM 14

5) Promotion of preventive and accessible health care
NPM 1, NPM 2, NPM 3, NPM 4, NPM 5, NPM 6, NPM 7, NPM 9, NPM 12, NPM 13, NPM 17, NPM 18
SPM 5 (Medicaid-eligible children who receive dental services)

6) Reproductive and sexual health
NPM 8, NPM 15, NPM 17, NPM 18
SPM 1 (unintended pregnancy)
SPM 2 (abstaining from alcohol use during pregnancy)
SPM 6 (abstaining from cigarette smoking during pregnancy)
SPM 9 (public, middle and secondary schools that require comprehensive sexuality education as a part of their health curriculum)

7) Unintentional injuries
NPM 10
SPM 4 (fetal, infant and child deaths reviewed for preventability)
SPM 7 (firearm deaths among youth aged 5-19)

8) Family and Community Health Bureau capacity development
The FCHB Section Managers and staff continued to review and refine the section work plans to insure that the activities and goals were represented and related to the Bureau strategic plan and that their objectives met the SMART (specific, measurable, achievable, realistic and time-bound) format. Subsequently, the Bureau plan's goals and activities were reviewed and modified as needed and accomplishments were noted throughout the past year. //2008//

/2009/

The Bureau continues to use the 2005 Needs Assessment document as the foundation for their ongoing revisions to the Blueprint for Maternal and Child Health in MT., which serves as the

Bureau's strategic plan in addressing the eight priority areas originally identified in the 2005 Needs Assessment. The priority areas are: 1) Environmental Health; 2) Family Support and Education; 3) Mental Health and Substance Abuse; 4) Nutrition and Obesity Prevention; 5) Promotion of Preventive and Accessible Health Care; 6) Reproductive and Sexual Health; 7) Unintentional Injuries; and, 8) Family and Community Health Bureau Capacity Development.

The MCHC Supervisor has taken on the role of ensuring that each of the eight priority areas includes feasible objectives based on the capacity of the responsible section, as well as ensuring that the Blueprint includes the outcomes for the previous year's objectives. Within each priority area, new objectives for Fiscal Year 2009 have been identified and assigned to a FCHB Section(s) responsible for its implementation. Throughout the coming year, the FCHB will be meeting to specifically address the new 2009 Objectives. Additionally, based on discussions with the individual sections, a significant number of objectives are continuing into the next fiscal year.

The Blueprint for Maternal and Child Health in MT also includes a reference to the Public Health and Safety Division's Strategic Plan and to the Bureau's 2007 Legislative Goals which were required prior to the start of the 07 Legislature. It is anticipated that within the next 2 months, the Bureau will submit their 2009 Legislative Goals. //2009//

/2010/

The Blueprint for Maternal and Child Health in Montana serves as the Bureau's Strategic Plan for addressing the priority health care needs for Montana's MCH population as identified by the 2005 MCH Needs Assessment. The Blueprint captures the Bureau's ongoing addition of new objectives and outcomes for the previous years and how several of these support the Public Health and Safety Division's Strategic Plan. The 2007 and 2009 Legislative Goals are also included in this document.

As the Bureau proceeds with completing the 2010 MCH Needs Assessment Report, plans are underway for the Family Health Advisory Council (FHAC) and the Bureau to initiate the process of developing new state performance measures at the October, 2009 FHAC Meeting. Subsequent quarterly FHAC meetings will be spent discussing the potential new measures. State performance measures will be finalized at the April 2010 face to face FHAC meeting.
//2010//

An attachment is included in this section.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	2	2	7	9	17
Denominator	2	2	7	9	17
Data Source					MT newborn screening and follow-up program
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2008
2008 was the first year Montana had mandatory hospital-based screening of newborns for 28 genetic conditions. This performance measures includes the results and follow-up for those tests. The increase in the number of conditions is due to the increase in the number and types of tests conducted.

a. Last Year's Accomplishments
The Montana Newborn Metabolic Screening Program (MNMSP) is a partnership between CSHS, the Montana Public Health Laboratory (MT-PHL), and the baby's medical home provider. The overall goal of the Montana Newborn Metabolic Screening Program is that every newborn with an initial positive or screen positive result is tracked by the CSHS program coordinator to a normal result or appropriate clinical care.

Montana Senate Bill 162, passed in 2007, authorized expansion of the mandated newborn screening panel to the recommended national standard of 28 conditions (plus a separate hearing screen) as endorsed by the American Academy of Pediatrics and the American College of Medical Genetics (ACMG). CSHS initiated adoption of amended Administrative Rules of Montana in late 2007 to implement expanded screening in 2008. CSHS played a key role informing the public, clinic coordinators, health care providers, and others regarding the NBS program changes. SB 162 also provided funds to CSHS for contracted long-term follow-up services for all screened conditions. CSHS staff developed a Request for Proposal in late 2007 which secured availability of long-term follow-up services by the time mandated expanded screening was implemented on January 17, 2008. The Montana Medical Genetics Program at Shodair Children's Hospital in Helena was awarded this contract. The follow-up contractor recruited for and filled key positions in early 2008. Contracted consultants were available to primary providers at a dedicated cell telephone number to maximize communication with providers who might not be familiar with the expanded panel of screened conditions.

CSHS recruited, hired, and trained a Newborn Screening Program Coordinator with extensive background in laboratory testing and molecular genetics, who began work on January 2, 2008. In February 2008, the program coordinator attended a five-day fully supported training at Duke University in tandem mass spectrometry theory, screening practices, and diagnostic testing for conditions detected by tandem mass spectrometry. The NBS coordinator prepared an article on the expanded screening program for the June 2008 issue of the statewide Public Health "Prevention Opportunities Under the Big Sky"

MT-PHL received all bloodspot specimens and screened for pheylketonuria, galactosemia, congenital hypothyroidism, hemoglobinopathies, and cystic fibrosis. Specimens were then shipped to the Wisconsin State Laboratory of Hygiene for completion of the screening panel. With expansion, the fee charged by the MT-PHL for the mandated panel doubled, and covered only the costs of testing. More than 4% of babies needed a repeat screen due to unsatisfactory specimens or out of range test results on the initial newborn screen. The NBS coordinator was responsible for short term follow-up to ensure that repeat screening occurred, and facilitated secure information sharing of positive screening results with the long term follow-up contractor. The NBS coordinator matched screening records to birth certificates as soon as possible and

identified babies who needed screening. Of the 12,455 infants who received at least one Montana newborn screen in 2008, 41 were screen positive for one of the 28 mandated conditions. Of these, 17 were diagnosed with a condition and are being treated. An additional 26 infants were presumed carriers of abnormal hemoglobin traits and referred for follow-up genetic services. Babies with diagnosed conditions in 2008 include nine with congenital hypothyroidism, one with PKU, one with a galactosemia variant, one with a disorder of fatty acid metabolism, one with organic acidemia, three with cystic fibrosis, and one with sickle cell anemia. More than 99% of Montana newborns in 2008 received at least one bloodspot screen.

.

In September 2008, the NBS coordinator, laboratory supervisor, and a medical geneticist employed by the long-term follow-up contractor made a site visit to the Wisconsin laboratory. This facilitated streamlining of some specimen and result handling procedures. It also clarified Wisconsin standards for possible and probable abnormal specimens, as well as special procedures for hospitalized babies receiving nutritional supplementation.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn metabolic screening data with Montana birth certificates				X
2. Identify babies with Montana birth certificates who have no newborn screening data within two months of their birth and determine reason for no screening		X		
3. Ensure that all newborns with confirmed conditions are referred to the contractor for long-term follow-up and consultation with the primary care provider in the medical home.		X		
4. Ensure partners and decision makers review program statistics, accomplishments, and challenges to improve sustainability and accountability for the program.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The MNMSP continues to consolidate, evaluate and improve the systems put in place in 2008 with expansion of the newborn screening panel. The coordinator attended the American Public Health Laboratory (APHL) Newborn Screening Symposium in 11/08, and participates in the MSGRCC (Mountain States Genetics Regional Collaborative Center) newborn screening workgroup.

The coordinator helped present a program update to a state-wide clinical laboratory meeting in 4/09. Feedback from parents and providers guided revision of a new parents' brochure listing screened conditions (attached). CYSHCN updated the program website (http://newborn.hhs.mt.gov).

In 6/09, the NBS coordinator position was re-defined under the supervision of the MT-PHL. The coordinator prepared a draft "Lost to follow-up protocol" in 8/09 (see the attachment) for babies

with initial invalid or out of range results. Partners and decision makers reviewed program statistics (% babies screened, initial positives, screen positives, confirmed diagnosis, treatment), accomplishments, and challenges for calendar year 2008 in order to improve sustainability and accountability for the program.

Program partners (CYSHCN, laboratory, follow-up contractor) meet monthly. Procedural issues are being resolved to allow formation of a Montana NBS Work Group. Since Montana's testing for most of the expanded panel of conditions is performed in Wisconsin, standards developed by the Wisconsin Advisory Group provide useful guidance.

An attachment is included in this section.

c. Plan for the Coming Year

A very high percentage of Montana's newborns (more than 99%) are receiving at least one bloodspot screen that now includes the ACMG/ AAP recommended panel. However, the field of newborn screening is in a period of constant change and challenge to increase the timeliness of testing, reduce costs, implement improved testing technology, streamline interoperable data management and reporting, and possibly increase the numbers of conditions screened. Montana CSHS has provided leadership to encourage partners and decision makers to plan a sustainable future for the MNMSP. Montana's current NBS fee is one of the highest in the nation (due to lack of economy of scale with only 12,000 births) and pays only for reagents, laboratory personnel, and general MT-PHL infrastructure.

There is also a new and evolving awareness that newborn screening programs need to become more consumer focused. Consumer service opportunities include improved access to provider and parent education materials; enhanced education of nurses, midwives, and laboratorians to reduce the number of unsatisfactory specimens requiring re-collection; and partnership with the MT-PHL to provide screening reports which track screening to completion, offer clearer recommendations, and are readily available to the newborn's medical home. The MNMSP will use finalized guidelines (LA-31) from the Clinical and Laboratory Standards Institute (CLSI) to improve and clarify the Administrative Rules of Montana regarding screening premature and/or sick newborns. The follow-up contract was extended to December 31, 2009. A concurrent formal assessment of contractor compliance will help determine if the program is meeting the needs of infants and children diagnosed with screened conditions, and those of their families.

In 6/09, the NBS coordinator position was re-defined under the supervision of the MT-PHL. The coordinator has more direct access to laboratory data, and is now the "single point of contact" with submitters and providers for information about the program. The coordinator relays abnormal and invalid results directly to providers to give them more complete, consistent, and clinically relevant information. Enhanced coordinator access to the laboratory information system should permit extraction of quality assurance data for submitter feedback. Follow-up educational efforts to submitters will focus on reduction of the percentage of invalid specimens (currently almost 3%) to more closely parallel that of the Wisconsin program (1.4%). CHRIS (Child Health Resource Information System) software will have improved NBS functionality and will continue tracking newborns with initial out of range screening results to a normal result or appropriate clinical care.

The partners (CSHS, MT-PHL, and follow-up contractor) will continue to meet regularly and co-operate in educational endeavors. Efforts will continue to initiate a NBS Work Group to provide expert clinical and stakeholder guidance to the program.

An attachment is included in this section.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	54.5	55	55.3	55.6	56.5
Annual Indicator	54.0	54.0	54.0	56.5	56.5
Numerator	188	188	188		
Denominator	348	348	348		
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56.5	56.5	56.5	56.5	56.5

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) continued to have regular contact with Dr. Laura Nicholson, who provides clinical guidance and chairs the Children's Special Health Services Advisory Subcommittee of the Family Health Advisory Council. The subcommittee membership meets twice a year and have the following roles and responsibilities: 1) Provide information from providers, service users, and others to promote short and long range planning to meet the health care needs of children and youth with special health care needs (CYSHCN) as defined by the Program; 2) Review and advice regarding policy decisions indicated as a result of changes in federal statutes, federal requirements and regulations, state plan amendments, administrative rules, and state legislative actions; 3) Monitor, review, and evaluate the allocation of resources and access to health care services for children served by the program; 4) Identify service gaps and unmet health care needs of CYSHCN statewide and make recommendations to the Department; and 5) Review and provide input on health care initiatives and proposals regarding CYSHCN.

CSHS and Parents Let's Unite for Kids (PLUK) developed the "Montana Parent's Handbook on Transition: Adult Living", released in May 2008, which provides comprehensive transition information for CYSHCN parents/clients. CSHS also assisted PLUK on the Family to Family Health Information and Education Center Grant application. PLUK was awarded the grant, which includes activities aimed at addressing the transition issues faced by the CYSHCN population and their families.

The CSHS Advisory Subcommittee underwent changes to expand community and parent

representation. The subcommittee invited another parent representative from Missoula and an invitation was accepted by Parents Let's Unite for Kids (PLUK).

The Western Region Pediatric Specialty Clinic (RPSC) conducted a survey of parent's whose children attended the endocrine, cleft, pulmonary, rheumatology, metabolic, and genetics clinics. The results indicated 90% considered their clinic experience was "great, 8% indicated their experience was "good," and the other 2% reported their experience was "okay" or "poor." Clients/families continued to receive an informal exit interview prior to leaving a RPSC visit. The exit interview allows parents/youth time to pose any unanswered questions, as well as to inform the coordinator of their suggestions or concerns related to improving their clinic experience.

Clients/families continued to receive an informal exit interview prior to leaving a RPSC visit. The exit interview allows parents/youth time to pose any unanswered questions, as well as to inform the coordinator of their suggestions or concerns related to improving their clinic experience.

The Client Satisfaction Surveys indicated that some families were unable to attend the Pediatric Specialty Clinic due to the distance from the clinic location, up to 300 miles one way and the increased gas prices compromising their already limited budget. CSHS recognized this as a barrier for specialty clinic participation and in response formed an Advisory Subcommittee work group in May 2008 to explore how to supplement the Medicaid travel reimbursement so parents are able to keep their child's appointment(s). Administrative constraints prohibited this type of assistance.

CYSHCN parents participated in a number of activities this past year. The January 2008 interview process for the Newborn Screening Program Specialist was staffed by a parent. A parent reviewed and provided policy recommendations for the Child Health Referral and Information System (CHRIS), the CSHS client tracking software application. A parent representative attended the 2008 AMCHP Meeting in Washington, DC and recommended that CSHS hire a Parent Advisor. The CSHS Advisory Subcommittee recognized the need for this position; however, DPHHS hiring and budget constraints necessitated this suggestion being placed on hold. A CYSHCN parent reviewed and assisted with writing the CSHS section of the MCH Block Grant application.

CSHS staff maintained personal communication with CYSHCN parents and discussed with them how best to maximize the CSHS stipend earmarked for their child's uncovered medical services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continued active parent participation in CSHS Advisory Subcommittee to the Family Health Advisory Council.				X
2. Review comments from exit interviews for program modifications at the Regional Pediatric Specialty clinics.				X
3. Ongoing collection and analysis of the client satisfaction survey from the Regional Pediatric Specialty clinics.				X
4. Parent participation and input on the CSHS activity plan.				X
5. Partnership building with Parents Let’s Unite for Kids (PLUK), MSDB, parents and CSHS.				X
6. CSHS Medical Director to continue to provide technical assistance and guidance.				X
7.				
8.				
9.				

10.				

b. Current Activities
The client satisfaction survey process will be repeated at the RPSC for Cystic Fibrosis Clinic clients, during April-July 2009. Health coverage questions were added to the survey. This data will be used to evaluate clinic services and determine whether this population is being referred to all possible resources.

The CSHS Advisory Subcommittee work group continues to evaluate ways to assist families with transportation costs to specialty clinics and recommended follow up services. This activity was suspended due to lack of resources.

CSHS continues to promote parent participation by sponsoring attendance at condition specific workshops and through expanded parental participation on the CSHS Advisory Subcommittee. A parent representative attended the 2009 Early Hearing Detection and Intervention (EHDI) conference in Dallas and recommended all agencies need to work together to build a system of care for infants and children identified with hearing loss. A parent representative attended the June, 2009 Subcommittee meeting.

Parents continue to determine how they want to spend their CSHS financial support for their child's diagnosis and treatment plan.

CSHS participates on the Part C Advisory committee which consists of parents, providers, partners and state agency representatives.

The RPSC exit interview process continues with the Nurse Coordinator visiting with each family to assure that their questions are answered and to confirm they understand the next treatment steps.

c. Plan for the Coming Year
Historically and true through today, CSHS would like to fund a position for a program Parent Representative. CSHS has identified many ongoing areas where a parent representative(s) would be of assistance to the program including, data development, clinic evaluation and development, etc. As CSHS continues to work towards this goal, the program will continue to have parents involved in developing and reviewing program policies. The advisory subcommittee will also continue to explore parent involvement. The meeting minutes can be found at http://www.dphhs.mt.gov/PHSD/family-health/cshs/cshs-index.shtml

CSHS plans to finalize the work begun in the summer 2009 assessing the Newborn Screening Follow-up Program and Metabolic Clinic. The process includes information gathered from 19 interviews conducted with parents and medical providers who received services from the vendor, whose contract is end-dated December 2009. A summary report will be written focusing on the vendor's contract compliance and effectiveness of the program. The report will be used to suggest modifications and required improvements to the vendor's future contract.

CSHS will continue to work with families in determining how to best utilize their allotment of $2000 for direct pay. CSHS will also continue to facilitate communication between families and providers when addressing expensive out of state genetic testing.

Dependent on staffing availability, CSHS plans to explore outside funding sources to fund SHS staff and CYSHCN families' attendance at diagnosis specific conferences. Also dependent on staffing resources, is the ability for CSHS to research family grant opportunities which would offer additional financial and educational resources to the CYSHCN families.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	52.2	60.2	52.6	52.6	50
Annual Indicator	51.7	51.7	51.7	45.9	45.9
Numerator	361	361	361		
Denominator	698	698	698		
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	50	50	50	50	50

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

a. Last Year's Accomplishments
CSHS continued to participate on the Montana Academy of Pediatrics (MAAP) subcommittee to address topics such as reimbursement rates, transportation issues, and how to increase the number of children with a medical home. CSHS staff and the regional nurse coordinators attended the MAAP meeting in September. Changes to the Newborn Screening Program were shared during the meeting.

Pediatric Specialists provided In-services for pediatricians, family practice physicians, and other providers at the Regional Pediatric Specialty Clinics. The specialist included: Anthony Bouldin, MD, Pediatric Neurology (Seattle); Peggy Schlesinger, MD, Pediatric Rheumatology; Jerald Eichner, MD, Pediatric Pulmonology; Jeff Wagner, MD, Pediatric Pulmonology (Denver); Michael Narkowitz, MD, Pediatric Gastroenterology (Denver); Michael Kappy, MD, Pediatric Endocrinology (Denver); Susan Apkon, MD, Pediatric Physiatrist (Denver); Marilyn Manco-Johnson, MD, Pediatric Hematologist (Denver); Ruth McDonald, MD, Pediatric Nephrology (Seattle). These regional educational meetings offered learning opportunities as well as facilitating communication between the medical home and specialty providers. Medical students, nursing students, hospital staff and others also attended these presentations.

Clinic Coordinators continued to be directly responsible for ensuring that each child seen in the Regional Pediatric Specialty Clinic (RPSC) has a primary care provider (PCP) and that all treatment recommendations from specialty clinics are communicated to the PCP for coordination and continuity of care.

CSHS continued to collaborate with Dr. Laura Nicholson, the CSHS medical advisor, who provides project planning advice, identifies strategies to define the medical home concept, and continues to promote the medical home concept within the statewide pediatric community.

The CSHS section supervisor attended the Annual Association of Maternal and Child Healthcare Partnerships meeting in Alexandria, VA in 2008 to obtain information about how to actualize the medical
home concept in a rural state like Montana. One especially relevant seminar emphasized the importance of communication among healthcare providers to maintain and support the child's medical home. This issue continues to be a topic of discussion for the CSHS Advisory Subcommittee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All regional pediatric specialty clinic participants are tracked and referred to medical home as needed.		X		
2. Continue to support and update the CSHS website, which includes medical home links.				X
3. CSHS also plans to continue to strengthen the relationships between the pediatric specialty clinics and primary care providers				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Web enabling the Child Health Referral and Information System (CHRIS), the CSHS database began in November 2008. Functionality is under development to allow a child's PCP to view clinic schedules with specialty provider information, to make electronic client referrals for clinic evaluations, and to access newborn screening information for their clients. The target date to complete this project is 2011. The electronic capability will provide PCPs with current information about available services statewide and do much to facilitate care for newborns and CYSHCN.

CSHS has worked to explore a viable medical home definition and will continue to work with Dr. Laura Nicholson. The medical home concept is promoted at the regional specialty clinics and primary care providers are invited to attend and are sent their patient's clinic report. According to data collected at the regional clinic sites and through the CSHS program, most of Montana's CYSCHN have some type of health care coverage. Several health care coverage plans include medical home programs which influence medical providers due to contractual or financial relationships.

National Academy for State Health Policy is allowing applications for a year-long program of technical assistance to up to eight states seeking to improve the availability of medical homes in

their Medicaid and Children's Health Insurance Programs. The CSHS manager partnered with Medicaid staff and submitted an application.

c. Plan for the Coming Year

During the coming year, CSHS plans to identify and assess the many medical home related activities and medical home definitions. This activity is anticipated to include researching a number of sources, i.e. HRSA, Parents Let's Unite For Kids (PLUK), insurance companies, and agencies contracted to provide services to the CYSCHN population. Additionally, since each entity has their unique definition of medical home that information will also be collected. The intent is to establish a baseline of current activities, resulting in CSHS having a better understanding of program strengths, weaknesses, opportunities, and threats so as to promote coordinated, comprehensive care. Throughout this process, CSHS plans to continue working with the subcommittee chair, Laura Nicholson, MD, for ongoing program support and representation.

CSHS also plans to continue to strengthen the relationships between the pediatric specialty clinics and primary care providers by timely responses to their requests for reports that can be generated through Child Health Referral and Information System or by accessing the information from the internal CSHS tracking systems such as for contract payments.

Montana was awarded one of eight National Academy for State Health Policy (NASHP) TA Grants. This one year grant will allow participation in the new Consortium to Advance Medical Homes for Medicaid and Children's Health Insurance Program (CHIP) Participants. We have committed to work together, with the support of NASHP (through a grant from The Commonwealth Fund), to develop and implement policies that increase Medicaid and children with special health care needs access to high performing medical homes. The medical home is identified as an enhanced model of primary care in which care teams attend to the multi-faceted needs of patients and provide whole person comprehensive and coordinated patient-centered care.

The technical assistance program is expected to provide opportunities for consortium members to exchange insights and experience with national experts and their peers, as well as both in-person and distance learning and both group and individual assistance.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	50.3	78.5	50.4	50.5	55.2
Annual Indicator	48.8	48.8	48.8	55.2	55.2
Numerator	350	350	350		
Denominator	717	717	717		
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	55.2	55.2	55.2	57	58.5

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments
Children's Special Health Services (CSHS) and Regional Pediatric Specialty Clinic (RPSC) staff assessed client health care coverage at every contact with children and youth with special health care needs and their families. CSHS continued partnering with the Child Health Insurance Program (CHIP) and Medicaid to increase access for needed benefits for Children and Youth with Special Health Care Needs (CYSHCN).

CSHS facilitated discussions between CHIP, audiologists and the Montana School for the Deaf and Blind (MSDB) regarding hearing aids options, determining fee schedules and replacement insurance coverage. As of October 1, 2008, hearing aides became a covered CHIP benefit and CSHS began covering the cost for the hearing aide warranty and batteries as CHIP is not able to cover these supplies.

CSHS provided limited financial assistance to families for specialty care during FFY 2008. A total of 61children/families received an average of $1045.00 in assistance for medical care and prescription services.

CSHS continued to partner with the Disability Determination Bureau to provide SSI applicants with information about the availability of other programs that may provide them with assistance. These families contact CSHS for a variety of issues, including where they can access assistance with education services, payment for services not covered by Medicaid, where they may obtain additional evaluations which may qualify their child for SSI, and transportation concerns.

Current year billing of insurance companies for metabolic and cleft/craniofacial clinics has provided additional revenue to augment the RPSC sites. The specialty care at the regional pediatric clinic sites save many families from the necessity of costly travel out of state to access services.

During FFY 2008, 65% of active CSHS clients had a source of payment for health care including private insurance, 43%; Medicaid 26%; Indian Health Services (IHS) 1%; and health coverage status was unknown for 29%. Health coverage information is collected on the RPSC consent form at the time of clinic. A preliminary data review indicated that 92% of active RPSC clients had a health coverage payment source; however a significant number are still in need of CSHS assistance due to high deductibles or required services and supplies that are a non-covered expense.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Continued limited financial assistance for medical services	X			
2. Continued partnership with Medicaid program regarding specialty services in Montana.		X		
3. Ongoing shared referrals with CHIP		X		
4. Communication with providers to accept negotiated rate.		X		
5. Provide information to CHIP and other insurance regarding coverage needs of CSHCN.				X
6. Provide information to health care providers regarding the Healthy Montana Kids expansion		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Regional Pediatric Specialty Clinics (RPSC) and CSHS continue to educate families about their
health coverage options such as CHIP, Medicaid, and private insurance.

CSHS is currently surveying Cystic Fibrosis clients regarding health payment status. The Regional Coordinators received continuing education regarding health care coverage for this population.

Since October 1, 2005 CSHS staff has billed Montana Medicaid, CHIP, and about 20 private health insurance plans for cleft/craniofacial and metabolic clinics. As of June 30, 2009: $880,400 was billed for cleft/craniofacial interdisciplinary clinics and $486,359 was paid; and $213,300 was billed for metabolic interdisciplinary clinics and $93,550 was paid. Approximately $500,000 has not been paid; resulting in other sources paying the balance or the balance is forgiven. CSHS continues to address the outstanding balance as this revenue allows families to receive medical care instate.

CSHS had planned to provide more ongoing education to RPSC staff about private insurance options, prior authorization, waiting periods, and pre-existing exclusions, but were unable to accomplish this due staff resources being utilized elsewhere.

In FFY 2008 CSHS received 95 applications. Sixty-one clients were eligible for up to $2,000 in health care coverage assistance. Of this 61: 8 were self-pay; 7 were CHIP; 4 were Medicaid; 1 was Medicare; and the remaining 41 had some type of health coverage as a primary payer.

c. Plan for the Coming Year

CHIP was expanded during the Montana 2009 Legislative session to cover families up to 250% of the federal poverty level. Expansion of CHIP will begin October 2009 and is anticipated to provide health coverage for an additional 29,000 Montana kids. This expanded program is called Healthy Montana Kids (HMK). As CSHS currently assists families at 200% federal poverty level or below, some families currently receiving assistance will be eligible for HMK; therefore CSHS's role in providing financial assistance will be reviewed.

Currently, CSHS provides financial assistance for CHIP eligible families for non-covered services, such as durable medical equipment. In the coming year, CSHS intends to discuss with Healthy Montana Kids and Medicaid possible policy changes whereby they will offer adequate coverage for specific conditions, for example the coverage of continuous positive airway pressure (CPAP) devices or home nebulizers. CSHS will continue to offer limited financial assistance to families that qualify by condition and financially.

The majority of families receiving financial assistance from CSHS continue to be underinsured; therefore, CSHS plans to work actively to provide information to health care providers regarding the HMK expansion. CSHS will continue working with the Regional Pediatric Specialty Clinics sites to distribute information to families and providers.

CSHS staff plans to explore family grant opportunities through different avenues, including insurance companies, with the intent of identifying potential additional financial assistance as well as assisting the family with the application process.

CSHS plans to assess if staff can take on additional efforts to work with health care agencies to address health care coverage issues, such as childhood obesity, which is a difficult and very concerning health condition that involves several co-morbidities. Montana has a Center for Medicare and Medicaid Bariatric Surgery Center of Excellence; however, it is focused on the adult population. Surgical and non-surgical options (regarding service delivery) in Montana have not been a focus as of yet.

CSHS continues to explore the feasibility of expanding the inter-disciplinary team billing process for Cystic Fibrosis Clinics. Previous billing and hence, the education of health care payers has furthered the recognition of the importance of team care for CYSHCN. Our efforts are supported by the healthcare payers and their recognition of the cost benefits of team care in the development of a coordinated comprehensive plan of care for kids with complicated medical conditions.

CSHS staff plans to provide more ongoing education to RPSC staff about private insurance options, prior authorization, waiting periods, and pre-existing exclusions.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	72.2	72.4	72.6	72.8	88.6
Annual Indicator	71.6	71.6	71.6	88.6	88.6
Numerator	250	250	250		
Denominator	349	349	349		
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88.6	88.6	88.6	90	90

Notes - 2008

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments
CSHS maintained financial support for the three Regional Pediatric Specialty Clinics (RPSC) that served 2913 children, which is a 5% increase in the number of clients served from the previous year. Two reservation Cleft/craniofacial clinics located in Wolf Point and Browning served 23 clients. The Western RPSC moved to a new location in May 2008. The new site is very child and family friendly, has good parking, and is located near the hospital campus. See the attachment for Regional Clinic vists.

CSHS provided ongoing continuing education for the RPSC Coordinators, which included a presentation from the Montana School for the Deaf and Blind (MSDB) on how to diagnosis deafness and loss of hearing and the current treatment options and recommendations. Collaboration with the Utah Leadership Education in Neurodevelopmental Disabilities Regional Program (ULEND) allowed the CSHS to provide additional metabolic nutrition training to the RPSC. CSHS also provided, on an as needed basis, financial support for a specialist, such as Helena's Pediatric Neurologist, to travel to a RPCS.

CSHS continued ongoing evaluation of the services provided at the RPSC sites with Client/Parent Surveys and exit interviews. This information is used for coordinator training, informing the Advisory Sub-committee, clinic providers, and the CSHS staff with client/parental insights on improving clinic services.

CSHS continued in their role as a network provider whereby CSHS directly bills insurance companies, such Blue Cross Blue Shield, Aetna, CIGNA, and United Health Care for allowable procedures completed at the RPSC. This additional revenue is allocated to the RPSC in their yearly CSHS contracts and funds the Cleft/craniofacial and Metabolic inter-disciplinary clinics.

CSHS collaborated with public and private community based partners such as Indian Health Services (IHS) MSDB, the Shodair Children's Hospital Medical Genetics Program, The Follow the Child Project foster child home visiting program, and Parent's Let's Unite for Kids. These partnerships are the community strength of CSHS and its mission and programs.

CSHS participated on the Medicaid Targeted Case Management (TCM) Work Group to assure representation of Children and Youth with Special Health Care Needs (CYSHCN) in case management issues. TCM is an important funding source for public health home visitors to ensure CYSHCN are linked to services and assure coordinated community follow-up.

In July of 2008, CSHS was awarded an Early Hearing Detection and Information (EHDI) grant from Centers for Disease Control. The EHDI funds have, in part, been used to start the process of converting the Child Health Referral and Information System (CHRIS) client server software application to a web application. CHRIS is the CSHS client tracking software used by the Montana School for the Deaf and Blind (MSDB) and the RPSC for tracking infants and young children, identified through universal newborn hearing screening to have significant hearing loss requiring services from MSDB. This shared software application now provides electronic referrals between programs and facilitates coordination of client services and is in keeping with the long range plan for CHRIS enhancements.

CSHS continued active outreach to other public and private agencies that provide services to

CYSHCN. Staff completed community visits to Bozeman, Helena, and Great Falls and explained the CSHS services to hospital discharge staff, public health nurses, Newborn Intensive Care Units/nursery staff, and Part C early intervention staff.

As of January 2008 legislation, all newborns are screened for the 28 conditions, as recommended by the American Academy of Pediatrics and American College of Medical Genetics and a hearing screen. This program involves partners with the Montana Department of Public Health & Human Services Laboratory, Wisconsin State Laboratory, CSHS, the pediatric regional clinics, and Shodair Children's Hospital. The newborn screening program mandates the screening and the contract with Shodair Children's Hospital assures clinical support and consultation for diagnosis and follow-up treatment.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHS will maintain its current web site to provide information and links to important sites for parents and medical providers.			X	X
2. CSHS staff will continue to participate in the Medicaid TCM work to assure a funding source for public health home visiting to CYSHCN.				X
3. CSHS plans to continue contacting payers that are not reimbursing clinic visits, with the intent to increase payments.				X
4. Ongoing financial support, training and consultation for Regional Pediatric Clinic sites.		X		X
5. Continue partnership with Parents Lets Unite for Kids (PLUK)				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHS continues to collaborate with and provide support to the three RPSC sites, Wolf Point and Browning outreach sites. Pediatric Rheumatology clinics were suspended in May of 2008 but will restart at the Western RPSC in July 2009. A new pediatric pulmonologist is moving to Montana this year; therefore CSHS staff is preparing for changes to the Cystic Fibrosis Clinic.

CSHS will maintain its current web site to provide information and links to important sites for parents and medical providers. The Montana Medical Genetics program is now accessing the CHRIS data system, used by the MSDB and the RPSC. CHRIS facilitates tracking of genetic clinic schedules, as well as Newborn screening follow-up services. Web-enabling the CHRIS application, funded by the EHDI grant began in October of 2008 and has undergone updates this past year.

CSHS staff will continue to participate in the Medicaid TCM work to assure a funding source for public health home visiting to CYSHCN. CSHS manager is conducting TCM training to providers. The goal is to help these partners know how to enroll with MT Medicaid, update on the changes in claim submission, educate providers regarding what are and are not billable services, and provide information about who to call when the providers have questions.

Discussions are ongoing with Parents, Let's Unite for Kids (PLUK) as to how to maximize similar services.

c. Plan for the Coming Year
CSHS plans to continue contacting payers that are not reimbursing clinic visits, with the intent to increase payments. Staff will also continue working with Medicaid, CHIP and private payers regarding medical service and supply coverage needs for CYSHCN with the goal to increase their awareness that each child's situation and condition is unique and typical covered and non-covered policies do not always meet their medical needs.

CSHS staff plans to continue to conduct TCM program development and training with community partners, to expand public health home visiting to CYSHCN. At present the TCM program lacks a payment methodology, current provider manuals and training opportunities; therefore, it is expected that once the TCM program is utilizing a Centers for Medicaid and Medicare approved payment methodology that the rates will increase. This work is in conjunction with designing and providing TCM trainings to local providers with the aim of enhancing TCM service delivery.

CSHS plans to continue to support RPSC expanded inter-disciplinary clinics for patients with cystic fibrosis (CF). Pediatric pulmonologist, Dr. Jerry Lysinger, who is affiliated with Denver Children's Hospital, is moving to eastern Montana this year. CSHS is working with our program medical advisor, the CF center director, and others to facilitate his transition to the CF clinic and the RPSC. The western region of Montana will again have a pediatric surgeon in residence in September 2009. Back up for this position is provided by Seattle Children's Hospital.

Pediatric arthritis clinics, which began in late summer 2009, will again be offered in Montana. In 2008, these clinics were suspended due to funding constraints. The goal is to have this clinic at the three RPSC sites within the year.

St Vincent's Healthcare submitted a Pediatric Epilepsy Telehealth grant which would provide pediatric follow-up neurological care to children, previously evaluated by a pediatric neurologist, with epilepsy age 0-18 throughout Montana. Montana currently has no pediatric neurologists resulting in pediatric neurology services being contracted to Seattle for two regions. At this time, all three regions are currently recruiting for a Pediatric Neurologist with CSHS providing assistance as requested.

In the coming year, CSHS and PLUK will continue their work addressing a number of collaborative efforts supporting their respective programs. Some of these opportunities include: PLUK being a presence at CSHS sponsored clinics, PLUK partnering in training opportunities to families regarding health care, and PLUK involvement in case consulting to support families.

The long range CHRIS System Enhancement Plan includes allowing primary care providers (PCP) access to the RPSC schedules for timely referral of their patients to specialty care and allowing PCP access to the newborn screening results which they can share with parents.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	6.5	6	6	6.5	46.5
Annual Indicator	5.4	5.4	5.4	46.2	46.2

Numerator	8	8	8		
Denominator	147	147	147		
Data Source					CSHCN Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46.5	46.5	46.5	47.5	47.5

Notes - 2008
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments
CSHS staff attended the Mountain States Genetics Regional Collaborative Center's meeting and the Montana Children's System of Care Conference both of which addressed the issue of transitioning youth to adult care was discussed. It was identified that often the youth's pediatric specialist is willing to continue their relationship with the youth due to lack of lack of adult specialty providers familiar with their condition.

The American Cleft Palate Association requested CSHS assistance for planning their April 2008 Pre-Conference Symposium in Philadelphia, at which time transition issues were discussed. The transition issues Montana's Cleft/craniofacial population and teams face are very similar to those of other teams. The ages and stages of transition and treatment were discussed in relation to growth issues. The challenge for many youth with cleft/craniofacial conditions is completing treatment prior to losing their health coverage and becoming tired of ongoing treatment. To address the transition issues, Montana continued focusing on getting kids into team care early, encouraging families to actively participate in the care and decision process, reviewing health coverage status at each clinic visit so that families have adequate coverage to access care.

Let's Unite for Kids (PLUK) and CSHS collaboratively developed the handbook "Montana Parent's Handbook on Transition: Adult Living," which provides comprehensive transition information. The Regional Pediatric Specialty Clinic (RPSC) Coordinators, CSHS, PLUK and the Office of Public Instruction coordinated the May 2008 distribution of the handbook to parents that attend clinics, primary care providers, CSHS advisory subcommittee and it was used as a handout at the pediatric conference.
The publication is available at http://www.pluk.org/Pubs/PLUK_Adult_High_School_04_2008.pdf).

CSHS staff and the RPSC coordinators acknowledge that transition is something to prepare for; therefore, each RPSC encourages transition and independence stages as each family and child is capable through one to one discussion with youth and family

A FCHB Staff member was appointed to the advisory board of the Montana Transition Training, Information and Resource Center (MT-TIRC) in 2008. This board provided input on a number of projects providing access to timely, high quality transition information, training, and resources for young people with developmental disabilities, their families, and their communities. The information from board meetings was shared with the CSHS staff and the CSHS Advisory Subcommittee.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide limited support to youth receiving financial assistance for Children's Special Health Services (CSHS) and at regional clinic visits regarding health care transitions		X		
2. Offer financial support and information to pre-teens and teens for peer educational opportunities				X
3. Communicate and provide input to the MT-TIRC Advisory Board				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

With input from the CSHS Advisory Subcommittee, CSHS planned to develop a standard transitional care questionnaire for use at the RPSC. This questionnaire would focus on the medical
transition from childhood to adulthood, including managing the condition, obtaining health coverage and services, and follow through with the treatment plan. This goal was not accomplished due to lack of staff resources.

A staff member continues to serve on the advisory board of the Montana Transition Training, Information, and Resource Center. Some of the projects that have been developed during the year include a series of twelve web-based conferences available to young people with disabilities and their families which provide information on topics such as self advocacy and customized employment, and an emerging leaders and mentors program. The Board's mission continues to be to provide trainings and resources to prepare young people and their families before transition and to make the transition process less cumbersome.

Staff continues to be involved with workgroup meetings of the Mountain States Genetics Regional Collaborative Center to identify regional resources and collaborations for medical home transitioning. Resources have been identified for possible adaptation for Montana, including those from The National Alliance to Advance Adolescent Health as well as the National Secondary Transition Technical Assistance Center.

c. Plan for the Coming Year

Transition will continue to be addressed at RPSC visits throughout the clinic attendees different developmental stages.

The CSHS manager will work with the Montana Medical Genetics Program at Shodair Children's Hospital to specifically focus on gaps in the health care system for young adults that have metabolic conditions that require special diets. This is of particular concern for young women with phenylketonuria planning to become a parent.

CSHS will make Cystic Fibrosis (CF) health coverage survey information available to the RPSC coordinators, CF clinic providers and Primary Care Providers (PCPs). Specifically, the survey asks about Social Security Administration (SSA) assistance with the understanding that in Montana SSA eligibility assures eligibility and coverage by Medicaid. Transitioning from public programs to private health care coverage is difficult to maneuver, therefore awareness is important. RPSC coordinators will provide SSA eligibility criteria for all CF clinics in an effort to bring awareness assist families and enhance health coverage for those that could utilize these benefits.

CSHS staff will continue to send transition information with CSHS financial applications and provide information to families regarding transitioning from health care programs such as Medicaid and CHIP to other payment sources.

The FCHB staff member who has been serving on the advisory board for Montana Transition Training, Information, and Resource Center was reappointed. She will continue to attend board meetings and provide information about relevant transition projects to the CSHS staff, clinic coordinators, and the CSHS Advisory Subcommittee.

Transition issues in Montana are addressed by several agencies, i.e. PLUK, Office of Public Instruction; however there appears to be a lack of leadership on the state as a whole. CSHS will consider the possibility of initiating communication with the agencies with the intent to develop a consistent message that would be used by each agency.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	91	80	80	80
Annual Indicator	90.9	79.6	73.6	75	72.6
Numerator	2603	12952	12231		
Denominator	2864	16271	16618		
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	80	80	80	80

Notes - 2008

The source of data is the National Immunization Survey (NIS), July 2007-June 2008 Table Data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_0708.htm). The data for 2008 are not yet final. Please note that the 95% confidence interval for this indicator is +/- 6.7.

Notes - 2007
The source of data is the National Immunization Survey (NIS), 2007 data (http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2007.htm). Please note that the 95% confidence interval for this indicator is +/- 6.2. A numerator and denominator were not readily available for this data, therefore none are included. These data were updated with final 2007 data for the July 15, 2009 submission.

A survey of providers indicates that the average vaccination rate among children who are able to access a provider is 81.2%. This rate includes Varicella as one of the antigens. The series evaluated in the 2007 provider survey was 4DTaP: 3Polio: 1MMR: 3Hib: 3HepB: 1Varicella. Using a census estimate of 11430 two year olds in the state, this survey would indicate that 9,281 children who were seen by providers had completed their immunizations by the end of their second year.

An electronic immunization registry was established in Montana several years ago. Participation in the registry has been gradually increasing since its inception. Until the statewide registry is more complete, Montana will continue to use the NIS as the source of data. According to the NIS survey, 65.3% (+/- 6.9) of two year olds had completed the series of 4DTaP: 3Polio: 1MMR: 3Hib: 3HepB: 1Varicella. Using the same census estimate, this would indicate 7,795 children were up to date by the end of their second year. The NIS survey includes children who may not have a medical home.

Notes - 2006
The source of data is the National Immunization Survey (NIS) (http://www.cdc.gov/vaccines/stats-surv/nis/tables/0506/tab03_antigen_state.xls). Please note that the 95% confidence interval for this indicator is +/- 6.3. The numerator and denominator are estimates based on the NIS report of 73.8% of MT children 19 to 35 months with appropriate vaccination coverage. The denominator is pulled from the estimated population of MT children listed in the NIS 2006 User's Guide.

A survey of providers indicates that vaccination rates among children who are able to access a provider (the data source in previous year) remain high, around 90%. The data source was changed to the NIS this year, and 2004 data were revised to reflect NIS data to be in closer compliance with the MCHBG guidance.

An electronic immunization registry was established in Montana several years ago. Participation in the registry has been gradually increasing since its inception. 2006 registry data reported 7145 children who have completed their immunization schedule by the end of their second year. Using an census estimate of 11692 two year olds in the state, this provides an indicator of 61.1%. However, not all providers participate in the registry and not all IHS sites are reporting. We expect the indicator from this source will increase as reporting improves. In the meantime we will use the NIS as the source of data.

a. Last Year's Accomplishments
The Reading Well Collaborative partnership with Medicaid and the Office of Public Instruction (OPI) continued in 2008. This collaborative partnership was developed several years ago when Medicaid was doing charts pulls to verify how Medicaid dollars were used for children immunization. It was determined that it would be easier and benefit both Medicaid and the State Immunization Program to use the statewide immunization information system (SIIS). To encourage parents to allow their children's vaccine history to be entered by the local health jurisdiction into the SIIS, they were given a children's book. The partnership with OPI began in March 2004 and the ages of participation were subsequently extended to include all Montana

children aged 4 years or older who received their kindergarten shots.

Electronic import of records from the birth registry into the SIIS was implemented in the Fall of 2008.

All Vaccine for Children (VFC) providers were visited in 2008 by State Immunization Staff. Problems identified regarding vaccine storage, handling and delivery issues in 2007 that required corrective action were re-evaluated in 2008.

The Cervical Cancer Task Force completed their evaluation of the HPV vaccine issues in Montana. The HPV vaccine, purchased with $400,000 of state funds, was made available to county health departments, Title X clinics, and Community Health Centers for children 9 years-18 years who are insured but have policies with high deductibles or co-pays. Other eligible females were those aged 19-26 years who have no other means to pay for the vaccine. The HPV vaccine was available on July 1, 2008. The adolescent nurse consultant developed the vaccine distribution plan and worked with schools and public health to provide educational materials. Additionally, approximately 3900 doses of HPV were distributed to public clinics.

In October of 2008, 3 new vaccines were added to the VFC program: DTaP/IPV/Hib, used for the first four doses of the DTaP series; DTaP/IPV, used for the fifth dose of the DTaP series; and, a 2-dose Rotavirus vaccine. The WIZRD (Web-base Immunization Registry Database) continued to track these and all other vaccines given by the immunization providers. WIZRD is a web-based registry that in addition to recording individual's immunization history, also records disease history for chickenpox. By identifying those adolescents that have had chickenpox, efforts can be concentrated during a school or community chickenpox outbreak on the adolescents and younger children that have not received 2 doses of varicella vaccine.

Montana's immunization rate continues to be low compared to other states. The reasons for this low rate include: 1) the difficulty of completing series. Although single antigens may score high on completion rates, random gaps in serial coverage quickly lead to substantial declines in vaccination; 2) Drop out rate. Using 06-07 data, the low coverage level for the fourth DTaP vaccine reflects a drop-out rate of -18.8% from DTaP3. Although, coverage of 92.7% is not bad, for DTaP3 this rate is not achieved until children are 24 months of age (NIS). All children should have received the third dose of DTaP in the sixth month of life, yet the rate of administration by the end of the sixth month was 68.1%. The low coverage level seen for the fourth DTaP vaccine likely reflects missed opportunities to vaccinate when children return to a practice during their second year of life and may also indicate lack of a successful patient tracking system.; and 3) Refusal to give doses of varicella vaccine. Montana's rate for one dose of 1 dose of varicella vaccine at age 2 has risen to 78.5% but additional work should be done for enforcing the daycare rules.

While the 4th dose DTaP immunization rate for 2 year old children in Montana as measured by the National Immunization Survey rose to 79.1% from 78% in 2008, this is still an important area for improvement. Increased immunizations will assist in lessening the impact of pertussis on the local communities.

Regional Immunization Workshops for Local Health Jurisdictions were conducted during this last year. These workshops were the annual opportunity to provide updates as well as training in the 5 regions of the State of Montana.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Clean up and de-duplicate data in the statewide immunization				X

information system (SIIS)				
2. Provide education for birth registrars on completing birth registry information and recording of the Hepatitis B birth dose in SIIS			X	X
3. Conduct an assessment of immunization practice with SIIS				X
4. Provide SIIS education to school nurses, local hospitals, emergency rooms, and private provider offices in local health jurisdictions on accessing immunization records			X	X
5. Assess vaccine status of children in daycare facilities				X
6. Assess vaccine status of children in kindergarten and 7th grade				X
7.				
8.				
9.				
10.				

b. Current Activities
The 2009 legislature appropriated $400,000 for purchase and outreach of all adolescent vaccines.

The Montana Immunization Program continues to encourage and support vaccination activities throughout the state, including:

1) Increasing varicella vaccinations, especially prior to day care attendance, and improving varicella surveillance.
2) Increasing Tdap/Td booster rates for children in grade 7 by encouraging active participation of school nurses and administrators, and public health nurses.
3) Increasing the DTaP immunization rate among 2-year olds.
4) Providing educational brochures regarding HPV for girls ages 9 -- 18 to schools for distribution to the parents.
5) Conducting Regional Immunization Workshops for Local Health Jurisdictions to provide updates and training.
6) Encourage testing of all pregnant women for Hepatitis B infection during every pregnancy and reporting of rositive test results to state or local health departments for case management and follow up.

Provider use of WIZRD continues to increase. The electronic import of immunization records from the Indian Health Service are currently conducted weekly by one Tribal Health Department. Work continues on establishing a Memorandum of Understanding with a second tribal health department.

c. Plan for the Coming Year
Immunization activities will focus on continuing to address a number of populations' immunization requirements. These include:
1) varicella vaccinations for day care attendance
2) improved varicella surveillance: including using WIZRD data to review histories of chickenpox infection and concentrating efforts during outbreaks on adolescents and younger children without 2 doses of the varicella vaccine
3) focusing on the Tdap/Td booster rates for children in grade 7 to decrease the number of pertussis cases in the school setting by encouraging active participation with school nurses and administrators, and local public health nurses; and 3) providing educational brochures regarding adolescent vaccines, including Tdap, meningococcal and HPV, to schools for distribution to parents

4) improving the DTaP immunization rate among 2 year olds to lessen the impact of pertussis on local communities.

Regional Immunization Workshops for Local Health Jurisdictions will be conducted during the coming year. These annual workshops are provided in each of Montana' five regions and provide trainings on new information and update information from previous trainings.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	18	15	9.6	17	16
Annual Indicator	17.3	17.0	17.6	16.8	18.6
Numerator	349	349	359	343	367
Denominator	20144	20551	20424	20388	19782
Data Source					Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	16	15	15	15	15

Notes - 2008
The numerator is the number of live births reported to the Montana Office of Vital Statistics for 15-17 year old female Montana residents in 2008. The denominator is the latest mid-year population estimate (May 2009 release) for females ages 15-17 in Montana in 2008.

Notes - 2007
The 2007 data were updated for the July 15, 2009 MCHBG submission with final vital statistics data and the updated (as of May 2009) census estimates.The numerator is births that occurred to MT residents 15-17 years of age in 2007. The denominator is the mid-year census estimate of females 15-17 years old in Montana (May 2009 release).

Notes - 2006
Numerator data includes births to resident teens (regardless of place of occurrence) ages 15-17 from vital records. Denominator data is census estimates for 15-17 year old girls in Montana in 2006. The objective for 2006 was determined based on data reported in previous years that made the indicator appear lower than it actually was. The denominator was updated with new census estimates for the July 15, 2009 submission.

a. Last Year's Accomplishments

Pregnancy prevention was identified as a need by adolescents in the 2005 Maternal and Child Health Needs Assessment. The Women's and Men's Health Section (WMHS) maintained contracts and provided technical assistance to 14 Delegate Agencies (DAs) offering services in 27 locations serving all 56 counties in MT. Three WMHS staff members served as state level contacts for technical assistance and data related issues.

The DAs assured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of these reproductive health services and supplies.

In the 2008 calendar year, DAs served an estimated 7,184 adolescents and also provided specific outreach projects designed for adolescents considered at high risk for teen pregnancy and birth.

The WMHS Program and Health Education Specialists and the FCHB epidemiologist were key resources for the collection of teen pregnancy data included in the updated 2007 Trends in Teen Pregnancies and Their Outcomes in Montana fact sheet. The Trends in Teen Pregnancies and Their Outcomes in Montana From 1991 - 2005 Report was finalized in May 2008 and distributed across the state to family planning and other health related agencies. The 2006 data showed that the teen pregnancy rate continues to drop for 15-19 year olds and is currently 47.8/1,000 representing a 21.8% reduction from the 1995 rate of 61.2/1,000. http://www.dphhs.mt.gov/PHSD/Women-Health/documents/teenpregnancyreport.pdf

The WMHS received a 5 year grant from the Department of Health and Human Services Office of Population Affairs (DHHS OPA) to increase male services. The funds enabled the DAs to evaluate what strategies were needed to create a more male friendly environment and ways to market to males. In 2008, the DAs reported an overall 5% increase in male patient numbers.

WMHS distributed special initiative funding from DHHS OPA to the Bridger Clinic for their Partners in Prevention Project. Bridger Clinic collaborated with several agencies to provide additional comprehensive sex education and family planning services to teen mothers and fathers and other at risk youth for teen pregnancy. With the assistance of 30 peer health educators Bridger Clinic reached over 1500 teens with pregnancy prevention information.

The Health Education Specialist organized the statewide campaign for Teen Pregnancy Prevention Month in May. The Health Education Specialist created outreach packets that included a press release, sample letters to the editor, posters, and educational brochures and distributed them to the DAs.

WMHS collaborated with the Office of Public Instruction (OPI) and submitted an application to the Centers for Disease Control that focused on creating a statewide task force, working in coordination with WMHS, OPI and local schools to examine high risk teen behaviors including pregnancy. Montana was not awarded the grant.

The Health Education Specialist, a member of a Region VIII Regional Training Advisory Council (RTAC), participated in their yearly planning meeting for selecting DA's trainings. The RTAC reviewed the Region VIII Title X Programs' Training Needs Assessment that is conducted bi-annually, and selected trainings that included education and clinical components.

The Health Education Specialist, a member of the State Family Planning Information and Education Committee (SPIEC), consisting of DA staff, met and reviewed and approved family planning materials and identified priorities for all DAs. The SPIEC identified Teen Pregnancy Prevention Month as a priority and continued to coordinate a statewide outreach campaign.

WMHS received a DHHS OPA Expansion Grant to increase patient numbers statewide. The

grant supplemented the DAs ability to expand services in underserved communities targeting low income women and men, including adolescents.

Due to staff turnover the Health Education Specialist did not attend the 2008 Parent Teacher Association Conference in Great Falls, MT.

The Program Specialists provided training on Teen Pregnancy Prevention at the fall 2008 Montana Public Health Association Conference which included: state data released May 2008, risk and protective factors, statewide indicators, best practices, and skills building for communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. WMHS continues to provide reproductive health services, technical assistance, and educational and outreach materials	X		X	X
2. WHMS distributes an on-line newsletter for all the DAs, to provide updated information on teen pregnancy rates and other relevant information			X	X
3. Meet and discuss materials and family planning priorities with the SPIEC				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

WMHS maintains contracts with 14 DAs, representing all 56 MT counties. The DAs provide reproductive health services, technical assistance, and educational and outreach materials to residents.

WMHS continues updating and providing information on teen pregnancy rates to the DAs.

OPA funding continues to be distributed to DAs for expanding male services; the Bozeman Teen Outreach & Pregnancy Prevention Project; for dispensing highly effective & emergency contraceptives; and for expanding services targeting low income women and men, including adolescents.

WMHS provided Teen Pregnancy Prevention Month toolkits to the DAs for the 2009 May Teen Pregnancy Prevention Month.

Montana Family Planning Administrators (MFPA) are exploring funding opportunities to create a statewide adolescent taskforce for the purpose of addressing teen pregnancy prevention strategies.

The Nurse Consultant continues to meet with RTAC, evaluating DAs and Region VIII Title X agencies training needs, and the May 2009 Training focused on adolescents, clinicians, and front desk staff.

SPIEC continues to meet and discuss materials and family planning priorities on a yearly or as

needed basis.

WMHS created an on-line newsletter that includes information on funding opportunities, upcoming trainings and events, and pertinent information for Title X agencies.

WMHS Health Educator attended the Reproductive Health Update Conference in Park City, UT in April 2009, and sent out updates through the WMH weekly newsletter

c. Plan for the Coming Year

WMHS intends to contract with the 14 Delegate Agencies to provide reproductive health services, technical assistance, and educational and outreach materials to residents that represent all 56 counties in MT.

MFPA will continue to explore funding opportunities to create a statewide adolescent taskforce to address statewide teen pregnancy prevention.

The State Family Planning Information and Education Committee (SPIEC), facilitated by the WMHS Health Education specialist will continue their yearly meetings focusing on promoting Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "I Know" Campaign through statewide outreach campaigns.

WMHS Health Education specialist will continue to meet with the Regional Training Advisory Council to evaluate training needs for delegate agencies and Region VIII Title X agencies. The May 2010 conference will focus on topics identified by Title X agencies in the training needs assessment.

WMHS Health Education specialist will attend at least one reproductive health conference that focuses on teen pregnancy prevention.

WMHS Program Specialist will gather data on teen pregnancy rates in Montana and distribute information to local DAs on current rates and trends. The data will be distributed in a Teen Pregnancy Prevention interim report in fall 2009.

WMHS Health Education and Program Specialists will start coordinating efforts, with the assistance of the MCH epidemiology unit, to update the current Trends in Teen Pregnancies and Outcomes in Montana report for 1994-2008 in preparation for the release in 2010.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	42	40	40	40	46
Annual Indicator	41.6	33.2	45.9	45.9	45.9
Numerator	4283	3413	4693	4693	4805
Denominator	10295	10295	10225	10225	10468
Data Source					05 06 Statewide OH Study, OPI 3rd Grade Enrollment
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	46	46	46	46	46

Notes - 2008
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2006-2007 school year, from the Montana Office of Public Instruction.

Notes - 2007
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2005-2006 school year, from the Montana Office of Public Instruction.

Notes - 2006
Numerator data are from a 2005-2006 school year oral health survey of third graders. The numerator was estimated using a weighted percent of 3rd graders who have received sealants. Denominator data are the number of 3rd graders enrolled in public schools for the 2005-2006 school year, from the Montana Office of Public Instruction.

a. Last Year's Accomplishments
The Oral Health Education Specialist (OHES) maintained contact with the Montana Oral Health Alliance (MOHA) members. The MOHA 5-Year Strategic Plan was updated as fluctuating membership and participation allowed. The MOHA plan continues to address the importance of sealants; however, funding constraints prohibited implementing a community based sealant program.

The Bureau assisted the Health Resources and Services Administration (HRSA), Office of Performance Review (OPR) in the planning of the State Strategic Partnership Session meeting held in Helena, MT on June 20, 2008. The 40 plus participants identified four action steps that were discussed during the meeting. These action steps were addressed for the coming year: 1) Develop stronger collaborations across the state to increase access to oral health services; 2) Increase funding for health centers to expand their services and strengthen their clinical staff; 3) Develop a continuing education course for dentists and physicians that provides the latest evidence base for oral health care treatment of children ages 0 to 3 years; and 4) Provide additional training for dental providers and Medicaid beneficiaries regarding the Montana Early Periodic Screening, Diagnosis, and Treatment (EPSDT) dental program. HRSA provided ongoing technical assistance, as well as financial support, during the completion of the action steps. This document is attached.

The FCHB MCH Epidemiology Unit and the OHES worked with Kathy Phipps, Association of State and Territorial Dental Directors, on Montana's National Oral Health Surveillance System report. The report is available at: http://apps.nccd.cdc.gov/nohss/IndicatorV.asp?Indicator=2

The Family Health Advisory Council (FHAC) recommended that the OHES develop a transition plan for phasing out the Fluoride Mouthrinse Program (FMR) and identify resources and mechanisms to support the Access to Baby Child Dentistry (ABCD) Program and other

mechanisms to enhance oral health in young infants and children. The decision to phase out the Fluoride Mouthrinse Program was made due to funding cuts and because evidence does not support its effectiveness as a broad, population-based intervention. However, health education activities with schools will continue and the ABCD program, an evidence-based program developed by the University of Washington, is a targeted approach for higher-risk populations who might otherwise not have access to dental resources. For more information go to: http://www.abcd-dental.org/ A copy of the FHAC Report is at: http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Offer training to dental health professionals				X
2. Support continued oral health education in schools and seek additional oral health funds				X
3. Collect and analyze data on sealants in children in the public school system				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Due to funding changes and staff turnover, the Oral Health Work Plan was reassessed in early 2009 and the position has been reformatted as a Health Education Specialist whose duties will include promoting oral health education activities.

All the Oral Health Summit action steps were implemented by blending HRSA, MDA, MT PCA, and FCHB financial resources. ABCD Training was offered to 77 dental health professions in May 2009.

Quarterly meetings were held with the MT PCA to discuss oral health related needs. Five CHCs began offering the ABCD Program on April 1, 2009, with the first monthly training provided in June 2009.

The FCHB queried the FMR stakeholders for input on the FMR Transition Plan which was approved by the FHAC at their April 2009 meeting. The FMR is slated to end 6/30/09. The FMR Plan supports the ABCD Program as well as continued oral health education in schools and securing additional oral health funds.

The handout, School Based FMR Program: To Promote Oral Health & Reduce Tooth Decay, incorporating the 07-08 FMR data was approved for distribution to the FMR coordinators and other interested stakeholders.

The FCHB submitted an oral health grant application, Improving Children's Oral Health in MT, which includes a sealant program. Notification is expected in September.

The draft summary report on the Montana 2005-2006 study of oral health needs among 3rd

graders and Head Start children was completed and is currently going through the review process.

c. Plan for the Coming Year

Through December 31, 2009, funding is available for the MT ABCD Partnership Program; thus allowing for the continuation of the monthly technical assistance conference calls with the CHCs. The CHCs are required to submit progress/data reports in August and November 2009. The MCH Epidemiology Unit will analyze the data and a final report will be written by the FCHB with an anticipated release date of spring 2010.

The summary report on the Montana 2005-2006 study of oral health needs among 3rd graders and Head Start children will be finalized and distributed to the Family Health Advisory Council, the MT Oral Health Alliance and other oral health stakeholders.

School-specific reports on school-based oral health screenings conducted in 2004-2009 are currently being drafted and will be distributed to the schools and oral health screeners. Data on sealants were collected as a part of the screenings and the reports will provide schools with some oral health data to use in prevention and program planning. The new Health Education Specialist will be a resource for the schools in planning oral health education activities.

The Health Education Specialist will be charged with participating on the Interdisciplinary Training Committee that was initiated by Sharon Kott, Montana Area Health Education Center (MT AHEC). The general purpose of this committee is similar to the MT Oral Health Alliance; therefore, the Family Health Advisory Council will discuss the continuation of the MOHA or if it would be a better use of resources to support the Interdisciplinary Training Committee's work.

If the oral health grant, Improving Children's Oral Health in MT, is funded, the FCHB will enter into a contractual agreement with a public or private agency to implement a community based sealant program. The grant also includes funding for continuing the work begun with the Oral Health/Food Stamp Program's MT ABCD Partnership Project.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	4.6	4.5	4.4	4.3	4
Annual Indicator	5.6	6.2	6.2	5.6	6.2
Numerator	10	11	11	10	11
Denominator	178212	177051	177559	177577	178508
Data Source					MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	6	6	6	5

Notes - 2008
Denominator data are from the updated July 1, 2008 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are the number of deaths to Montana residents 14 and under due to motor vehicle crashes, as reported to the Montana Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

Notes - 2007
Denominator data are from the updated July 1, 2007 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are from final vital statistics data for 2007 (updated for the July 15, 2009 submission) and include deaths to resident 0-14 year olds that occurred in Montana and elsewhere and were reported to the MT Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

Notes - 2006
Denominator data are from the updated July 1, 2006 census estimates for the population of 0-14 year olds in Montana (May 2009 release). Numerator data are from final vital statistics data for 2006 and include deaths to resident 0-14 year olds that occurred in Montana and elsewhere and were reported to the MT Office of Vital Statistics. Due to the small number of events, these data are reported as a 3-year moving average (as of the 2006 data).

a. Last Year's Accomplishments
FCHB provided educational handouts and website links to 30 local Fetal, Infant, and Child Mortality Review (FICMR) coordinators, the State FICMR team, and the Family Health Advisory Council about seatbelt safety. One resource was the March 2007 "Prevention Opportunities Under the Big Sky" Newsletter, which featured the article "Unintentional Injury Deaths in Montana Children: Most are Preventable," collaboratively written by the Public Health and Safety Division Medical Officer, the MCH Epidemiologist, and the state FICMR coordinator. The article included information about Montana's FICMR program and notor vehicle safety measures such as encouraging parents to install and use infant seats correctly. "Prevention Opportunities Under the Big Sky" Newsletter is a monthly PHSD publication and is available at: http://www.dphhs.mt.gov/PHSD/prevention_opps/MT-PH-prevent-opps-newsletters.shtml.

An additional resource that was also provided was the American Academy of Pediatrics (AAP) guide to car seats website (http://www.aap.org/family/carseatguide.htm).

FCHB collaborated with Healthy Mothers Healthy Babies (HMHB) Safe Kids Safe Communities (SKSC) and distributed car safety seat educational materials to local FICMR Coordinators, Public Health Home Visiting (PHHV)/Fetal Alcohol Syndrome Disorder (FASD) Projects, and other interested entities. Pamphlets from Healthy Mothers Healthy Babies on car seat safety were distributed to local FICMR coordinators to use in their communities.

FCHB continued to sustain the FICMR activities, including training opportunities; the collection and analysis of 2005-2006 FICMR data for the next report; providing assistance to local FICMR teams in accurately identifying preventable deaths; and serving as a resource for local public health agencies efforts in reducing the number of preventable deaths in their communities.

The State FICMR Coordinator completed an email survey to all local coordinators asking for their input on what was working and what needed to be improved with the FICMR program. Several coordinators requested a FICMR new-coordinator training to provide information on conducting a mortality review in their community. Another request was for a review on death certificates.

FCHB collaborated with HMHB, SKSC, MT Council for Maternal Child Health, DPHHS Bureaus, the Department of Transportation (DOT), the Office of Public Instruction, and the MT Highway Patrol, to explore preventive measures for reducing motor vehicle crashes and their resulting injuries by utilizing the FICMR data. Several prevention measures were identified and included the primary seat belt laws, car seat safety instruction and ongoing support of the graduated driver's license.

The rate of deaths due to motor vehicles among children 14 years and younger continues to hover around 6 per 100,000. Motor vehicle deaths are one of the leading causes of death for Montanans of all ages, and they become the leading cause and outpace other causes around 6-12 years of age.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FCHB and HMHB will continue their joint coordination of the Safe Sleep Project.			X	
2. Continue to support state and community FICMR prevention efforts through twice a year educational meetings, trainings, and ongoing technical assistance.				X
3. Review FICMR data on an annual basis, facilitating earlier identification of preventable deaths and earlier implementation of prevention activities.				X
4. Promote prevention strategies statewide through distribution of the 2005-2006 FICMR Data Report which includes Community Prevention activities.				X
5. Collaborate with local coordinators to review and revise the current FICMR Collaborate with the Injury Prevention Coordinator on prevention strategies and activities.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

FCHB continues to sustain FICMR activities with several training opportunities: the coordinator training included FICMR review basics, death certificate information and a Mock Case Review for 13 attendees.

The new State FICMR Coordinator trained 30 local FICMR coordinators on determining preventability of deaths and conducted a mock review. There was also discussion on the review tool, keeping local team members involved and an open discussion on prevention activities and lessons learned.

The FCHB Epidemiologist analyzed the 2005-06 FICMR data and assisted with the final report. The report was distributed to the local FICMR coordinators and is available online on the FCHB website.

The FICMR Emergency Medical Services for Children (EMSC) state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review Keeping Kids Alive, May 20-22, 2009 in Washington DC. MT specific information, i.e. graduated drivers license, car seat safety education, check stations, and information related

to the review of youth fatalities from motor vehicle accidents was highlighted on their poster board presentation, which is attached.

The FICMR Coordinator attends the quarterly EMSC Advisory Meetings, to provide FICMR related information. Information related to prevention will be shared with local coordinators.

The DPHHS's request from the 2009 Legislature for general funds supporting a State Injury Prevention position was approved.
An attachment is included in this section.

c. Plan for the Coming Year
FCHB and HMHB will continue their joint coordination of the Safe Sleep Project, with the FCHB ensuring that PHHV and FICMR staff continue their client referrals.

The FCHB staff will continue to support state and community FICMR prevention efforts through twice a year educational meetings and trainings and by being available as a resource via phone, email or in person contacts. The State Coordinator will share current journal articles and information received from national list-serves related to infant and child death prevention, with the local coordinators via email.

The State Coordinator will explore the feasibility of incorporating I-Linc or regional meetings for local FICMR coordinator trainings and meetings. This will allow for the potential of increased participation in meetings because of decreased travel time and time away from their offices. The importance of the local FICMR meetings is that they allow local coordinators an opportunity to network, share prevention activities and collaborate on lessons learned with their peers, thereby improving the sense of teamwork.

FCHB staff will provide training updates to local FICMR coordinators on how to accurately complete the FICMR data reporting form to ensure consistency in all reviews. These training updates will be included in the local coordinator biannual meetings. The trainings will include case examples of incorrect form completion and mock reviews, as well as a review of the 2005-2006 FICMR Data Report which includes community prevention activities.

The MCH Epidemiologist will work with FCHB staff on a process to review FICMR data on an annual basis, facilitating earlier identification of preventable deaths and earlier implementation of prevention activities. The FCHB will also assist the local FICMR teams in understanding their data findings and incorporating them into community level prevention activities.

FCHB will promote prevention strategies statewide through distribution of the 2005-2006 FICMR Data Report which includes Community Prevention activities. The report will also be available on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-resource.shtml

The State FICMR Coordinator will collaborate with local coordinators and the MCH Epidemiologist to review and revise the current FICMR data collection tool to ensure that the data collected is in its most usable form. The State Coordinator will work with Information Technology staff to update the state FICMR database.

The State FICMR Coordinator will continue to attend the quarterly EMSC Advisory Meetings to act as a resource for FICMR information and to relay pertinent prevention information back to the local coordinators.

The State FICMR Coordinator will meet at least quarterly with the Injury Prevention Coordinator to collaborate on prevention strategies and activities. Prevention activities and ideas will be shared with the local coordinators via email or during trainings.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			26	29	54
Annual Indicator		25.9	49.3	52.1	48
Numerator		3184			
Denominator		12283			
Data Source					National Immunization Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	54	55	55	56	56

Notes - 2008
The data reported for 2008 are National Immunization Survey data for children born in 2005. The data are not yet final. The confidence interval for this rate is +/- 7.6.

Notes - 2007
The data source for this measure is the National Immunization Survey (NIS). The breastfeeding results are reported by year of the infant's birth. In this case, the data are for infants born in 2004. The confidance interval for this indicator is +-5.9. In previous years WIC data were used to report on this measure, but the NIS were considered a better source of population-level data. The 2006 indicator was updated with final NIS data for the July 15, 2009 submission. The objective for 2007 was set based on WIC data, not NIS data, and so is not a good match with the indicator.

Notes - 2006
The data source for this measure is the National Immunization Survey (NIS). The breastfeeding results are reported by year of the infant's birth. In this case, the data are for infants born in 2003. The confidance interval for this indicator is +-5.8. In previous years WIC data were used to report on this measure, but the NIS were considered a better source of population-level data. The 2006 indicator was updated with NIS data for the July 15, 2008 submission. The objective still reflects the objective based on WIC data.

a. Last Year's Accomplishments
WIC's effort to increase breastfeeding and reduce the risk of obesity continued by providing financial, technical assistance and training support to the Ravalli, Deer Lodge, Cascade, Custer and Missoula/Salish and Kootenai Tribes Breastfeeding Peer Counselor Projects (BPCP). These WIC Programs served approximately 1,000 pregnant and breastfeeding women per month.

Deer Lodge and Custer maintained the expansion of their WIC service delivery areas. They did not increase the number of BPCP participants by 72, as planned, due to a reduction in local staff.

WIC utilized the standard BPCP Monitoring Tool for BPCP site reviews. One BPCP was

monitored, as scheduled in 2008 and there were no findings of non-compliance. WIC planned to evaluate the current BPCP monitoring tool, but due to other projects and work load, this was not completed. Another staff person is performing BPCP monitorings and will be able to provide input and comments for the evaluation.

Breastfeeding educational materials, providing a standardized breastfeeding message, written in English and other languages, especially Spanish, were purchased and distributed statewide to all pregnant women. The 27 local programs provided 432 single-user, 539 manual and 10 multi-user loaner breast pumps and 150 collection kits (for the multi-user) to breastfeeding women.

WIC purchased a number of multi-user pumps, collection kits and breast pads under the new partnership with the Oral Health/Food Stamp Project, which were distributed to the WIC locals.

Operational Adjustment Funds (OAF) facilitated the purchase of 11 self-study Certified Lactation Counselor modules and paid the registration fees for several local WIC staff to attend the Mother/Baby Symposium and the Montana State Breastfeeding Coalition (MSBC) Meeting.

The Breastfeeding Coordinator (BC) participated on the MSBC by attending the quarterly meetings and the annual training as well as working on projects aimed at increasing the numbers of low income women who initiate and continue to breastfeed. The Breastfeeding Coordinator attended the 2008 U.S. Breastfeeding Committee's Conference.

Suzanne Haynes, PhD, presented the "Results of a Social Marketing Campaign for Breastfeeding: The National Breastfeeding Awareness Campaign" and "Brief Overview of the Business Case for Breastfeeding Kit" at the 2008 WIC Training Day attended by 100 local WIC staff.

A WIC Futures Study Group (WFSG), composed of lead local public health officials, local program, and
state WIC staff, was formed during 2008 and met five times. The WFSG has discussed a number of topics including, the current and future WIC funding allocation formula, program direction, and how to provide quality WIC services into the future. For additional information, please see http://www.dphhs.mt.gov/PHSD/family-health/nutrition-wic/WIC-futures-study-group.shtml.

In 2008, the Food Package Task Force (FPTF), composed of representatives from grocers, food distributors, organic producers, participants, local and state program staff was formed to review the new WIC food package information. They held four meetings and 1) discussed food package options from a variety of view points; 2) made recommendations regarding food category choices, retailer requirements (grocers and farmers), and training materials for retailers and participants; and 3) assisted the state staff in developing an implementation plan for release of the new food packages. A Food Selection Subcommittee met several times to make recommendations about the additions of specific food products to the WIC Approved Food List.

Since Montana started using the NIS data to monitor rates of breastfeeding at 6 months, the rate has remained at around 50%. Due to small sample sizes for Montana, the NIS data tend to have fairly large confidence intervals, so differences between the years do not appear to be significant. With the passing of legislation supporting breastfeeding spaces in state government offices during the 2007 legislative session, breastfeeding has gained some additional attention in the state. Montana's rate of breastfeeding at 6 months appears to be high compared to the national rate as measured in the NIS, although the confidence intervals overlap somewhat. Using the 2004 data (reported for 2007), Montana's rate is also higher than the US and the confidence intervals do not overlap.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to provide breastfeeding education to WIC parents before and after the birth of their child.			X	
2. Sustain the Peer Breastfeeding Counselor Projects.			X	
3. Implement and provide training on MSPIRIT's tracking and reporting capacities.				X
4. Purchase and distribute standardized breastfeeding materials with American Indian cultural emphasis to the WIC locals.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WIC intends to continue their financial, technical assistance and training support for the BPCPs. WIC is working on the redistribution of BPCP funds.

By September 30th, four BPCP will be monitored this year. One finding requiring corrective action was determined at one of the BPCP.

The BC continues her MSBC involvement and assists with their grant submissions as needed.

WIC created an electronic communication system for sending their weekly newsletter, memos, training opportunities and educational materials. This method will continue as it has been favorably rated by the locals and others.

WIC applied for OAF to purchase additional Certified Lactation Counselor self-study modules and scholarships to breastfeeding conferences and workshops. The request was not funded in favor of other requests made by Montana, such as caseload maintenance and equipment replacement.

The WFSG continues to meet and provides suggestions on methods to increase WIC participation, i.e. mini-grants to local programs for outreach. The FPTF is meeting and working on new WIC food package training materials for the grocers and clients.

Initial training on the food package changes occurred at the 2009 Spring Public Health Meeting attended by about 105 WIC locals.

The WIC food dollars' budget was reviewed in June to determine the availability of funds for purchasing breast pumps for local WIC agencies. At this time, the funding does not allow for this purchase.

c. Plan for the Coming Year
MSPIRIT, the new data system for WIC, is scheduled for implementation this year; therefore training opportunities for learning MSPIRIT's tracking and reporting capacities are planned. Of interest is its capacities allowing state and local staff to track breast pump issuance; facilitate the cross-checking of appropriateness of food packages issued to mother and infant; updating of breastfeeding data at each visit, and a number of standardized reports with the option of customizing reports.

The new WIC food packages, which will be implemented this year, have several regulatory

changes. Bi-monthly conference calls with the local programs are scheduled for the coming year at which time changes will be discussed. Of importance is the breastfeeding mother's food package being altered to reflect her infant's age and the amount of recommended formula, if requested, also reflects the infant's age. See the attachment: New WIC Food Package.

Two local WIC program staff will attend the USDA's "Loving Support" breastfeeding training, designed to build staff competencies to promote and support breastfeeding in association with the changes to the breastfeeding woman and infant food packages. They will conduct train-the-trainer training for local WIC program breastfeeding coordinators in the coming year.

OAF will be requested for next fiscal year for the purpose of supporting state and local staff training on breastfeeding related topics and for purchasing breastfeeding materials for use with WIC participants.

Standardized breastfeeding materials with American Indian cultural emphasis will be replenished and distributed to the WIC locals.

The BC will continue to participate in the MSBC and plans to attend the United States Breastfeeding Committee's biennial conference. Local program staff will be encouraged to participate in the MSBC.

WIC was notified of being awarded two infrastructure grants, with September 30, 2010 as the deadline date for accomplishing the grants' activities. The Re-Branding Grant's focus is developing a logo, a possible catch phrase and design layout. Once these are determined all materials produced by Montana WIC will be modified to reflect the new brand, updating and unifying our image. The second grant, Farmers Market Grant's focus is to encourage WIC clients to use their fruit and vegetable benefits (cash value voucher) at farmers' markets for purchasing locally grown produce. The grant will support WIC's efforts of updating the nutrition educational material "Getting a Head Start with 5-A-Day" to the new brand of "More Matters," purchasing reusable bags and recipe books focusing on produce; and mini-grants for local programs to support activities at the Farmers' Market or WIC clinic. The activities might include taste testing, fruit and vegetable nutrition information games or tours of the market with the goal of exposing WIC clients to a wider variety of fruits and vegetables.

An attachment is included in this section.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	92	92	94
Annual Indicator	92.8	87.9	90.0	93.1	93.0
Numerator	10563	10157	11107	11403	11669
Denominator	11378	11551	12339	12249	12551
Data Source					MT newborn hearing screening system, Hi-Track
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over					

the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	94	94	94	95	95

Notes - 2008
The numerator data source for this measure is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from the Montana Office of Vital Statistics and includes births to Montana residents that occured in Montana in 2008. It does not include births to Montana residents that occurred out of state. 12,178 (97%) of Montana's calendar year 2008 birth cohort were born in hospitals, approximately 2.5% were born with professional attendants, and .5% were born at home without professional attendants. Of those born in hospitals, 96% were screened prior to hospital discharge.

Notes - 2007
The numerator data source for this is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from vital stats and includes births to Montana residents that occured in Montana in 2007. It does not include births to Montana residents that occurred out of state.

Notes - 2006
The numerator data source for this is Hi-Track. The numerator includes hearing screenings for infants born to Montana residents in Montana. The denominator is from vital stats and includes births to Montana residents that occured in Montana in 2006. It does not include births to Montana residents that occurred out of state. The denominator was updated with final vital statistics data for the September submission of the block grant.

a. Last Year's Accomplishments
Montana's Universal Newborn Hearing Screening and Intervention (UNHSI) program is based on the national "1-3-6" program standard: newborn screening completed by one month of age; needed audiologic assessment completed by no later than three months of age; and, appropriate early intervention before six months of age.

During calendar year 2008, the UNHSI manager reinforced the implementation of the amended original Newborn Hearing Screening legislation making it mandatory for all hospitals providing birthing services to perform NBHS prior to hospital discharge. The manager provided monthly feedback on matching of birth certificates with screening records, provided a list of babies needing repeat outpatient screening, required documentation in the tracking software of the name of the primary care professional (PCP) for every baby who completed NBHS without a Pass result, the date the PCP was informed of that screening result, and monitored that all required data elements were included in each record submitted in the tracking software. The manager will publicize the Percent Complete for each hospital with birthing services in rank order grouped in five categories depending on annual birth cohort. This has proven to be a powerful motivator for ensuring that sufficient resources are dedicated to performing, recording and reporting screening results to the state program.

In calendar year 2008, 95% of all Montana births received a hearing screening prior to hospital discharge and 97% were screened by one month of age, with 87% of the babies referred for audiologic assessments receiving those assessments by three months of age. The average age of identification of bilateral hearing loss was 1.8 months.

The manager also provided feedback to the midwives on how well they complied with reporting requirements for the education they must provide to their clients about the importance of NBHS before each newborn is one month old. The manager provided the local screening partners with

NBHS brochures, posters, rack cards, and screening report forms containing milestones for language development to be given to the parents prior to discharge. The manager also distributed NBHS brochures to WIC offices, local public health departments, urban Indian clinics, pediatricians and family practice doctors, and midwives. Grant funds were used to run the NBHS 30-second advertising spot on cable television for five weeks in the seven largest service areas in Montana on Discovery, Food Network, USA, Lifetime, and The Learning Channel. See the attached file.

The Montana School for the Deaf and Blind (MSDB) and the UNHSI program continued to work closely to ensure that the babies identified as deaf or hard of hearing are referred to the school for monitoring and provision/coordination of intervention services. CSHS and the MSDB use the same software to record and track services provided to children with special health care needs, including those who are deaf or hard of hearing. The UNHSI program made electronic referrals to MSDB in the Child's Health Referral and Information System (CHRIS) software of the twelve babies indentified in the screening and assessment tracking software, HI*TRACK(c). Three additional babies were assessed and found to have normal hearing. Four of the babies with confirmed hearing loss received services from Part C of IDEA, and 11 of the babies received early intervention services from MSDB. One baby with confirmed hearing loss died within a month of birth and prior to receipt of services.

Additional funding was obtained from the CDC Early Hearing Detection and Intervention (EHDI) program to support: more intensive quality assurance on-site contact over the three-year period of 2008 through 2011 with all local partners who screen, assess, and provide parental education about newborn hearing screening and assessment. The funding will also enable conversion of the CHRIS software used by the state to track diagnoses, continuing assessments and intervention services into a system providing web-based, role-defined access to mutual client records by professionals serving deaf or hard of hearing children.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Link newborn hearing screening data with matched newborn bloodspot testing data and birth certificate data.				X
2. Continue to contract for Help Desk technical assistance for use of the tracking software by birthing facilities and audiologists.				X
3. Track newborn hearing screening and audiological assessment results from the tracking software and communicate the results to screening and assessment partners statewide.			X	
4. Electronically refer infants diagnosed as deaf or hard of hearing to the Montana School for the Deaf and the Blind within six months of each child's birth.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The UNHSI manager continues to provide monthly e-mail and telephone technical assistance to hospitals, audiologists, and midwives to implement the state law adopted in February 2008 for newborn hearing screening (NBHS), midwife education of parents about the crucial importance of

NBHS for all babies born outside of hospitals, and reporting of audiological assessments. On-site reporting training by CSHS is combined with other funded travel to local screening and assessment partners. The UNHSI manager ensures that primary care physicians are aware of the contact information for the five audiologists who are qualified to perform a complete pediatric audiological assessment. A letter is sent to the primary care physician of each baby who completes NBHS without a Pass result. In order to establish screening opportunities for babies born outside of hospitals, the UNHSI manager worked with the Office of Public Instruction to secure an agreement that the audiologists who work with the public school system will also provide NBHS at no cost to parents. This service, in conjunction with hospital outpatient screening opportunities, is expected to increase the number of babies born outside of hospitals who receive NBHS. All babies diagnosed as deaf or hard of hearing are electronically referred to the Montana School for the Deaf and Blind for Early Intervention services by the UNHSI manager.

c. Plan for the Coming Year

The primary focus for calendar year 2009 will be to continue the technical and programmatic support of the local screening and assessment partners in the statewide UNHSI program to ensure the achievement of the "1-3-6" program standard. Special emphasis will be placed on techniques to reduce lost-to-follow-up (LTFU) occurrences in those hospitals with less than 95% completion of NBHS for all babies born in their facilities in calendar year 2008 (the first year screening and reporting was mandatory rather than voluntary). The CSHS Advisory Subcommittee and all local partners will be included in consideration of the efficacy of various LTFU techniques in the Montana population and service environment.

The UNHSI manager will continue to provide monthly feedback to the local screening partners about the matching of birth certificates with screening records, babies whose outpatient screenings have not been reported to the state, and compliance with the monthly reporting law. Annual summary data will be publicized to all hospital CEO's. The manager will publicize the Percent Complete for each hospital with birthing services in rank order grouped in five categories depending on annual birth cohort. This has proven to be a powerful motivator for ensuring that sufficient resources are dedicated to performing, recording and reporting screening results to the state program.

The UNHSI manager will continue to contact primary care professionals to provide the contact information for the five audiologists who are qualified to perform a complete pediatric audiologic assessment to assist the provider in reaching the state UNHSI program goal to secure a needed assessment by the time the baby is no older than three months of age. The UNHSI manager will continue to make electronic referrals of all babies diagnosed as deaf or hard of hearing to the Montana School for the Deaf and Blind as required in state law.

The UNHSI manager will continue to provide local screening partners with educational brochures, rack cards and screening results reporting forms for parents that include milestones for language development. Brochures also will be provided to midwives, pediatricians, family practice physicians, WIC offices, local public health offices, and urban Indian clinics.

Because additional funding was obtained from the CDC Early Hearing Detection and Intervention (EHDI) program, CSHS staff will provide intensive quality assurance on-site contact over the three-year period of 2008 through 2011 with all local partners who screen, assess, and provide parental education about newborn hearing screening and assessment. The funding will also enable conversion of the Child Health Referral and Information System (CHRIS) software used by the state to track diagnoses, continuing assessments and intervention services into a system providing web-based, role-defined access to mutual client records by professionals serving deaf or hard of hearing children.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	16	9	16	16	14
Annual Indicator	17.0	17.0	16.2	14	13.2
Numerator	38755	38755	37000		
Denominator	227972	227972	228000		
Data Source					National Survey of Children's Health
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	13	13	13	13

Notes - 2008
The data source for this is the 2007 National Survey of Children's Health. The 13.2% of children without insurance coverage is similar to in-state estimates of the number of children without health insurance. The confidence interval for this rate is 11.2-15.2.

Notes - 2007
The numbers reflect the estimated percent of children under 18 years of age who were not covered by any public or private health insurance at some point during the reporting year. An estimated 14% of children were without health insurance in 2007, which is approximately 34,000 children in Montana. These are the data used by the state's CHIP program.

Notes - 2006
The numbers reflect the number of children under 18 years of age who were not covered by any public or private health insurance at some point during the reporting year. Montana Kids Count is the source of these data, which is the same source used by MT CHIP. Discussions about the most appropriate way to estimate uninsured children are underway in MT DPHHS. This data source will be reviewed and may be revised for the 2009 MCHBG application.

a. Last Year's Accomplishments
CHIP continued to provide quality, comprehensive insurance coverage for Montana children. Due to legislative action taken during the 2007 legislative session to increase CHIP eligibility to 175% FPL, CHIP expanded its community partnerships ("CHIP Champions") and outreach efforts. In June 2008, CHIP provided health coverage for 16,576 Montana children.

At the end of FFY 2008 there were 16,576 children enrolled in CHIP and no waiting list. This represented a 25% increase in enrollment from the same time period in FFY 2007. The program continued to receive solid support from the Governor's Office, the legislature, families with CHIP coverage and the general public.

CHIP screens all applications for Medicaid eligibility and forwards all applicants who appear potentially eligible for Medicaid to local public assistance offices. The program refers to and

coordinates with Children's Special Health Services and Children's Mental Health Services. The program sends information about the Primary Care Association members (Community Health Centers, National Health Service Corps sites, and Migrant and Indian Health clinics) to all families who apply for CHIP.

CHIP also provides information and referrals to Blue Care, Montana Youth Care and Montana Comprehensive Health Association. Callers to the Department's Family Health Line can also receive resources and referrals to private, low-cost health insurance and other resources in their communities.

CHIP continues to develop its statewide network of health care associations, individual health care providers, schools, and other community agencies to increase CHIP awareness by distributing CHIP materials in their communities. The program also conducted the train-the-trainer workshops in communities throughout the state. CHIP conducted informational meetings with all seven reservation tribal health/IHS departments and five Urban Indian Clinics. These meetings emphasized how CHIP works in conjunction with Indian Health Services/tribal health and incorporated hands-on training to help families apply for CHIP. The program also developed and distributed a brochure insert and poster addressing advantages of Native American participation in CHIP.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Acquire state and local funds to match federal funds and continue to insure Montana children				X
2. Refer 100% of children not eligible for CHIP to other appropriate programs or plans		X		
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHIP continues to provide quality, comprehensive insurance coverage for Montana children.

In November 2008, Montana residents passed Initiative 155, which establishes the Healthy Montana Kids Plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. During the 2009 legislative session, the Montana legislature appropriated funds for the initiative. Healthy Montana Kids will be implemented October 1, 2009 and will expand eligibility to 250% of the federal poverty level. CHIP and Medicaid will continue to provide quality, comprehensive insurance coverage for Montana children as they work on implementing the expanded coverage. The new program is expected to not only greatly increase the number of children in the state with health insurance, but also to reduce the number of children who fall through the gaps between Medicaid and CHIP eligibility. Healthy Montana Kids is intended to facilitate continuous coverage of children whose families are under 250% of the federal poverty level, whereas previously coverage may have fluctuated if children's eligibility shifted from Medicaid to CHIP or vice versa.

c. Plan for the Coming Year
CHIP and Medicaid will continue their efforts to increase the number of children enrolled in the Healthy Montana Kids program. Children with health coverage have greater access to preventive and acute health care services. The ultimate goal is to improve the health of Montana children.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			25	30	30
Annual Indicator		26.6	32.5	33.6	33.7
Numerator		3447	3629	3706	3876
Denominator		12936	11169	11029	11492
Data Source					WIC Program Enrollment
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29	28	28	27	26

Notes - 2008
The reported denominator and numerator includes all children ages 2-5 enrolled in WIC during '08 starting 01/01/08 and ending 12/31/08. The numerator reflects all children with risk codes 16 and 17.

Although there was a fairly large increase in the percent of children ages 2 to 5 years receiving WIC services with BMI at or above 85th percentile from 2005 to 2006, since then there have been smaller but steady percentage increase reported by the WIC Program. The large change from 2005 to 2006 could be related to changes in the way the data are collected.

Notes - 2007
The reported denominator and numerator includes all children ages 2-5 enrolled in WIC during '07 starting 01/01/07 and ending 12/31/07. The numerator reflects all children with risk codes 16 and 17.

a. Last Year's Accomplishments
The Breastfeeding Coordinator (BC) participated in the Chronic Disease/Obesity Prevention Task Force. An outcome of the goal to increase breastfeeding was a partnership with the Nutrition and Physical Activity Program (NAPA) to work on breastfeeding activities. This partnership has continued with both being involved in the Montana State Breastfeeding Coalition (MSBC). NAPA has provided scholarship support for several local program staff to attend nearby conferences and workshops. NAPA presented at the 2008 Spring Public Health Conference on breastfeeding initiation and duration data.

The Montana State Breastfeeding Coalition operated as a subcommittee of Eat Right Montana (ERM) for the past year. This arrangement allowed MSBC to accept tax-deductible donations,

have an organized means of accepting payment, and apply for grant funding. To date MSBC has been unsuccessful in receiving grant awards.

WIC distributed the monthly ERM Newsletter to the 27 locals who in turn were encouraged to incorporate the newsletter in their press releases and to use the materials as a nutrition education resource.

WIC also received a number of posters created by local school children and produced for Montana Action for Healthy Kids. The topics were healthy eating and being active. See http://www.eatrightmontana.org/index.html

WIC's effort to increase breastfeeding and reduce the risk of obesity continued by providing financial, technical assistance and training support to the Ravalli, Deer Lodge, Cascade, Custer and Missoula/Salish and Kootenai Tribes Breastfeeding Peer Counselor Projects (BPCP). These WIC Programs served approximately 1,000 pregnant and breastfeeding women per month.

WIC purchased a number of multi-user pumps, collection kits and breast pads under the new partnership with the Oral Health/Food Stamp Project, which were distributed to the WIC locals.

A WIC Futures Study Group (WFSG), composed of lead local public health officials, local program, and
state WIC Staff, was formed during 2008 and met five times. The WFSG has discussed a number of topics including, the current and future WIC funding allocation formula, program direction, and how to provide quality WIC services into the future. For additional information, please see http://www.dphhs.mt.gov/PHSD/family-health/nutrition-wic/WIC-futures-study-group.shtml.

In 2008, the Food Package Task Force (FPTF), composed of representatives from grocers, food distributors, organic producers, participants, local and state program staff, was formed to review the new WIC food package information. They held four meetings and 1) discussed food package options from a variety of view points; 2) made recommendations regarding food category choices, retailer requirements (grocers and farmers), and training materials for retailers and participants; and 3) assisted the state staff in developing an implementation plan for release of the new food packages. A Food Selection Subcommittee met several times to make recommendations about the additions of specific food products to the WIC Approved Food List. The new food packages have been changed to emphasize the 2005 Dietary Guidelines which witnessed an increase in whole grains, more servings of fruits and vegetables and less fat. These changes in the food packages will do at least two things: 1) reinforce the messages of a healthy diet; and 2) provide foods which will reduce the risk of obesity (less fat, more whole grains/fiber and more fruits and vegetables/fiber to replace higher calorie choices).

Value Enhanced Nutrition Assessment (VENA) training provided by the State, focusing on cultural diversity, critical thinking and emotion-based messaging was attended by local WIC staff. Emotion-based nutrition messages incorporated into VENA are used to achieve health behaviors and health outcomes, which include healthy growth and weight gain or weight maintenance. With these tools, local program staff assessed a participant's readiness for change and helped them establish a goal to work toward to achieve a health outcome.

Local WIC staff continued to collect children's weight and height measurements at each certification, which determines the child's body mass index (BMI). Parents of a child determined to be overweight or obese status are provided additional WIC counseling as requested by the family at future WIC appointments.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work to achieve Goal 4 of the MT Nutrition and Physical Activity State Plan to Prevent Obesity and Other Chronic Diseases which is: to increase breastfeeding of Montana infants.				X
2. Disseminate the ERM Healthy Families Newsletter.			X	
3. Purchase breast pumps, collection kits and breast pads, and distribute to local agencies		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

VENA activities included a review of the techniques for participant assessment and education during a WIC 101 Training held this year. Draft VENA questions were created for placement in the MSPIRIT system when it is implemented next year.

Local WIC staff continued to collect children's weight and height measurements and use the information for determining the child's BMI and a child's overweight or obesity status. These issues can be addressed on an as needed basis or when requested by the child's family at future WIC appointments.

WIC intends to continue their financial, technical assistance and training support for the BPCPs. WIC is working on the redistribution of BPCP funds.

The WIC food dollars' budget was reviewed in June to determine the availability of funds for purchasing breast pumps for local WIC agencies. At this time, the funding does not allow for this purchase.

The WIC Futures Study Group continued to meet this year and provide suggestions to the state as to how to increase WIC participation i.e. mini-grants to local programs for outreach activities. The FPTF is meeting and working on training materials and methods for grocers and participant for the new WIC food package.

c. Plan for the Coming Year

The new WIC food packages, which are intended to follow more closely the 2005 Dietary Guidelines, will be implemented later this year. Significant changes include a reduction of the amount of fat in the food package, an increase in the number of offered whole grains, and the addition of fresh fruits and vegetables. Participants will have the option to redeem their fruit and vegetable benefit check for purchasing fresh fruits and vegetables and frozen vegetables at Farmers' Markets or grocery stores. See the attachment: New WIC Food Package.

Resources for training staff on VENA competencies will be located and reviewed. These materials will be used for new staff and review for current staff. State Plan policies and procedures will be reviewed for the MSPIRIT implementation and updated to reflect VENA within the new system to provide more participant-centered nutrition education.

WIC was notified of being awarded two infrastructure grants, with September 30, 2010 as the deadline date for accomplishing the grants' activities. The Re-Branding Grant's focus is

developing a logo, a possible catch phrase and design layout. Once these are determined all materials produced by Montana WIC will be modified to reflect the new brand, updating and unifying our image. The second grant, Farmers Market Grant's focus is to encourage WIC clients to use their fruit and vegetable benefits (cash value voucher) at farmers' markets for purchasing locally grown produce. The grant will support WIC's efforts of updating the nutrition educational material "Getting a Head Start with 5-A-Day" to the new brand of "More Matters," purchasing reusable bags and recipe books focusing on produce; and mini-grants for local programs to support activities at the Farmers' Market or WIC clinic. The activities might include taste testing, fruit and vegetable nutrition information games or tours of the market with the goal of exposing WIC clients to a wider variety of fruits and vegetables.

Over the next year, the implementation of MSPIRIT will occur. Leading up to that time and after implementation, WIC will be spending more time reviewing the reporting capabilities. Any changes to the system must be discussed and approved with the SPIRIT Users Group, which is composed of all the states using the system. It is anticipated the MSPIRIT will enhance WIC's capacity to more accurately track this performance measure.

An attachment is included in this section.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			15	15	14
Annual Indicator		15.9	15.9	15.9	15.0
Numerator		1668	1668	1668	1893
Denominator		10509	10509	10509	12595
Data Source					Live birth data, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14	14	13	13	13

Notes - 2008
These data are collected and reported by trimester of pregnancy, not month of pregnancy. 2008 is the first year smoking status has been available from the birth record by time period of pregnancy. The numerator and denominator include births to Montana residents that were reported to the Montana Office of Vital Statistics. This number is believed to be an under-report of the actual number of women smoking during the last trimester.

Notes - 2007
The numerator and denominator are from the 2002 PRAMS data collected from mothers in a Point-In-Time (PIT) state sample. This is the only source of population-level data available on maternal smoking during the last three months of pregnancy. Vital statistics currently does not

collect data on maternal cigarette smoking by gestational age.

A new birth certificate will be implemented in 2008 and will include a question on smoking prior to pregnancy and by trimesters of pregnancy. This is expected to provide a new source of data for this performance measure as of the 2010 MCHBG application.

Notes - 2006
The numerator and denominator are from the 2002 PRAMS data collected from mothers in a Point In Time (PIT) state sample. This is the only source of population-level data available on maternal smoking during the last three months of pregnancy. Vital statistics currently does not collect data on maternal cigarette smoking by gestational age.

A new birth certificate will be implemented in 2008 and will include a question on smoking prior to pregnancy and by trimesters of pregnancy. This is expected to provide a new source of data for this performance measure as of the 2010 MCHBG application.

a. Last Year's Accomplishments
The FCHB sponsored, Risky Beginnings training was attended by 80 individuals including Public Health Home Visiting (PHHV) home visitors and early childhood providers.

FCHB staff cleaned, organized and summarized five years of PHHV data.

In April, 2008 the PHHV reassessment project was initiated. To date, FCHB staff and PHHV stakeholders and contractors, met for three, face-to face meetings. As a result, seven workgroups were formed: data, funding formula, marketing, outcomes, program requirements, program training and Targeted Case Management. Each workgroup met via telephone conference over the summer and presented recommendations to PHHV stakeholders at a face-to-face meeting in August.

FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee that developed the State of MT Intimate Partner Violence and Sexual Violence (IPV/SV) Prevention Plan. The staff member provided expertise about the studies in the U.S. finding an association between domestic violence, substance use and smoking. Researchers hypothesize that smoking may act as a "stress reliever" in households that experience domestic violence.

FCHB funded 15 PHHV projects, two of which are located on one of Montana's seven Indian reservations. Enhanced PHHV services were provided to five of these sites and on an additional Indian reservation. Enhanced PHHV services included an additional team member, and a support specialist, who provided weekly home visits and intensive case management (ICM) to those women at the highest risk of substance use during pregnancy. Enhanced PHHV services are based on research indicating that 1) pregnant women who smoke cigarettes are nearly twice as likely to have a low-birthweight baby as women who do not smoke; 2) smoking slows fetal growth and increases the risk of premature delivery; 3) alcohol and illicit drugs can limit fetal growth and can cause birth defects; and 4) some drugs, such as cocaine, also may increase the risk of premature delivery.

FCHB provided standard training to PHHV providers. Topics included: an overview of the PHHV project; how to screen for depression using the Edinburgh Depression Screen, how to screen for alcohol use by using the T-ACE, a screening tool asking questions about: Tolerance, Annoyed, Cut Down and Eye-opener; tobacco cessation techniques; domestic violence using the American College and OB/GYN Tool (ACOG); and the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social and Emotional (ASQSE) developmental screening tool.

FCHB staff traveled to three of Montana's Indian Reservations to assess interest in expanding PHHV services to new locations. Information gathered from these visits was used to write a

Request for Proposal (RFP) for PHHV services on Indian reservations. One new PHHV project was funded on the Northern Cheyenne Reservation and the FCHB trained their staff on the PHHV requirements.

FCHB offered information on programs such as the Montana Tobacco Use Prevention Program (MTUPP) Quit Line, Women's Breast and Cervical Program, and the March of Dimes Prematurity Prevention materials to the PHHV and Fetal, Infant and Child Mortality Review (FICMR) programs.

2008 is the first year Montana has had data on smoking during the last trimester from the birth record. Additional years of data from this same source will indicate the trend in smoking. The 2002 PRAMS estimate of smoking during pregnancy was 15.9%. The birth record data is believed to be an underreport of the actual rate of smoking during pregnancy.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to fund PHHV/FASD Projects to promote smoking cessation during pregnancy.				X
2. Promote Montana's tobacco quit line as a resource for PHHV/FASD projects.			X	
3. Collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 16 PHHV and 6 Enhanced PHHV projects, 3 of which are on one of the 7 Indian reservations, continue to be funded, with FCHB staff providing standardized training on the PHHV assessment tools to the local PHHV providers. The Enhanced Projects continue to include a support specialist who provides Intensive Case Management to those women at highest risk of substance use during pregnancy.

FCHB continues coordinating the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breastfeeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB staff presented a summary of 2005-2007 PHHV data to PHHV providers.

FCHB participated on the DELTA statewide steering committee. Their State of MT Intimate IPV/SV prevention plan, which includes an implementation plan, was submitted to the CDC in April, 2009.

FCHB and MTUPP staff provided tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

c. Plan for the Coming Year

All the PHHV and Enhanced PHHV sites will be monitored at least once by the FCHB staff. The sites will be checked for their compliance with program requirements and the FCHB staff will provide technical assistance, as needed.

FCHB will continue to fund the 17 PHHV/Enhanced PHHV programs, which will be encouraged to promote the Montana Tobacco Quit Line through information and referrals to their pregnant women and infant/family units. The PHHV sites will also be encouraged to refer their clients to other community programs, specific to their community, whose mission supports their PHHV program of supporting and promoting healthy pregnancy outcomes.

FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers. The iLinc technology will be implemented to decrease time spent traveling in an attempt to reach PHHV providers and other public health providers working with women and children across Montana.

FCHB will promote and coordinate training on Motivational Interviewing technique, for use by PHHV teams. Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	9.5	10	10	10	9
Annual Indicator	17.7	26.4	19.2	16.3	11.9
Numerator	12	18	13	11	8
Denominator	67913	68097	67811	67574	67074
Data Source					MT Office of Vital Statistics and census estimates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	9	9	9	9	9

Notes - 2008

The numerator include deaths to Montana residents that were reported to the Montana Office of Vital Statistics. The denominator data is from 2008 census estimates for the population of 15-19 year olds in the state (May 2009 version). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

Notes - 2007
Death records from the Montana Office of Vital Statistics are the source of the numerator data. 2007 vital statistics data were finalized for the July 2009 submission and include suicide deaths to MT residents, regardless of place of occurrence. Denominator data are from the 2007 census estimates for the population of 15-19 year olds in the state (May 2009 estimates). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

Notes - 2006
Death records from the Montana Office of Vital Statistics are the source of the numerator data. 2006 vital statistics data were finalized for the September 2007 submission and include suicide deaths to MT residents, regardless of place of occurrence. Denominator data are from the 2006 census estimates for the population of 15-19 year olds in the state (May 2009 estimates). As of the 2006 data, the data for this performance measure are reported as a moving average due to the small number of events.

a. Last Year's Accomplishments
Federal funding cuts resulted in FCHB being unable to replace staff members responsible for coordinating the Statewide Youth Suicide Prevention (YSP) Projects. The FCHB provided financial and technical assistance financial to the 12 YSP Projects through 9/30/08 at which time the statewide YSP efforts were transitioned to the Statewide Suicide Prevention Coordinator (SSPC).

The 12 contractors provided suicide prevention activities in their communities, including Applied Suicide Intervention Skills Training (ASIST), TeenScreen, QPR and numerous education and outreach activities. Additionally, the FCHB regularly updated the ASIST website training schedule.

FCHB contracted with the Montana Mental Health Association (MMHA) to create and disseminate a youth driven public service announcement focusing on eliminating the stigma of mental illness and prevention of suicide, using VISTA volunteers. As a result, one of the local YSP projects worked with local high school students who wrote, directed and filmed a youth suicide prevention PSA's posted on the Myspace page: http://www.myspace.com/helenasuicideprevention

FCHB worked with the MT/WY Tribal Leaders Council's Planting Seeds of Hope (TLC/PSOH) Youth Suicide Prevention Project by attending their meetings and inviting the PSOH Project Director to provide updates at the YSP Task Force Meetings. The SAMHSA federal grant officer attended an August 2008 joint meeting of these two groups which was held in conjunction with the National SAMHSA Behavioral Health Conference. During the meeting, the FCHB staff was presented with a star quilt, recognizing their work in implementing community YSP projects in Montana and their efforts to assure state collaboration with the TLC/PSOH YSP project.

FCHB provided assistance and guidance to the local YSP projects by making available the DVD, A Parent's Guide to Recognizing Depression and Preventing Suicide: Know the Warning Signs.

FCHB offered guidance and consultation to the State Suicide Prevention Coordinator on the state's reapplication for Garrett Lee Smith (GLS) funding, by providing the original YSP proposal, Request for Proposal (RFP), and position description. Montana's reapplication for FFY2009 was not funded.

The YSP Project Director became a member of the Suicide Prevention Resource Center (SPRC)

Steering Committee and attended their February 2008 meeting and participated in their scheduled conference calls. Shttp://www.sprc.org

FCHB participated in monthly conference calls with SAMSHA's YSP grant officer, the cross-site evaluation contact, and the state YSP evaluator. The FCHB collected and entered the data required by the cross-site evaluation component of the GLS grant. The data included the products and services offered by the local YSP Projects. The results are available on the PSI (product and services inventory) website.

FCHB and the PSOH Director presented information on their tribal and state government collaboration at the annual YSP SAMHSA grantees meeting in December 2007.

On September 10, 2008, in conjunction with Suicide Prevention Week, a Day of Healing ceremony was held in the Capitol Rotunda. This event was coordinated by DPHHS and the MT/WY TLC PSOH. Lt. Gov. John Bollinger spoke at the event; the Capital School Choir sang, and Joe Iron Man, Sr., White Clay People (A'ani nin) Spiritual Leaders, Ft. Belknap Indian Community, led a healing ceremony for participants.

Local FICMR coordinators implemented these prevention activities: FICMR outreach focusing on prescription drug abuse, which included a disposal day for disposing of outdated or no longer in use drugs; The Yellow Ribbon Suicide Prevention Campaign which identified places for youth to get help when they or their friends are troubled; school and community gatekeeper training to help identify and refer youth at risk; general suicide education targeted to teens to help understand warning signs and support services; TeenScreen in two communities, to identify and refer students with problems that could be related to potential suicide; restriction of access to lethal means of suicide including community education on gun locks and removal of firearms in homes of high risk teens; and interventions after a suicide focusing on friends and relatives to help prevent or contain clusters and to help the adolescents and young adults cope effectively with the feelings of loss/ guilt that follow a suicide.

The rate of suicide deaths among youth appears to be decreasing.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB will serve as consultants to the State Fetal, Infant and Child Mortality Review (FICMR) team on topics related to community action to prevent youth suicide.		X		
2. The FCHB will collaborate with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana.			X	X
3. FCHB will remain as a representative on the PSOH Technical Advisory Board and will provide updates and report back current activities of the PSOH projects to local FICMR Coordinators and FICMR State Team and other interested parties.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Local FICMR teams continued to review child deaths in their community and make recommendations to implement community action related to the cause of death, if preventable.

FCHB and the YSP project evaluator wrote and submitted the final YSP project report to SAMHSA, using their guidelines.

Due to conflicts in schedule, FCHB staff were unable to attend any MT/WY PSOH Technical Advisory Board meetings during this time period.

The SPRC Steering Committee underwent a reorganization process; therefore, the telephone conferences were cancelled.

The Suicide Prevention Task Force was disbanded due to the fact that the state's application to SAMSHA for continued funds for suicide prevention activities was unfunded. The FICMR program continues to address suicide prevention activities at their coordinator meetings and trainings.

c. Plan for the Coming Year
Local FICMR Teams will continue to review child deaths and implement community activities related to prevention of youth suicide.

FCHB will remain as a representative on the PSOH Technical Advisory Board and will provide updates and report back current activities of the PSOH projects to local FICMR Coordinators and FICMR State Team and other interested parties.

The FCHB will continue to collaborate as requested or as needed with the Statewide Suicide Prevention Coordinator on efforts to prevent youth suicide in Montana.

The Statewide Suicide Prevention Coordinator is a member of the state FICMR team and will attend meetings and provide updates on youth suicide prevention activities in Montana.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	90	90	91	91	91
Annual Indicator	78.7	78.2	81.8	86.8	73.0
Numerator	100	97	126	138	108
Denominator	127	124	154	159	148
Data Source					Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2009	2010	2011	2012	2013
Annual Performance Objective	91	91	91	91	92

Notes - 2008
The data source for this measure is live birth records from the Montana Office of Vital Statistics. In 2008, Montana had three level 3 facilities (facilities for high-risk deliveries). The numerator and denominator include births that occurred in Montana, regardless of the mother's place of residence.

Notes - 2007
The data source for this performance measure is the MT Office of Vital Statistics. In 2007, Montana had three level 3 facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include infants born in Montana, regardless of the mother's place of residence.

Notes - 2006
The data source for this performance measure is the MT Office of Vital Statistics. 2006 data were finalized for the September submission of the Block Grant. In 2006, Montana had three level 3 facilities (facilities for high-risk deliveries and neonates). The numerator and denominator include infants born in Montana, regardless of the mother's place of residence. df

a. Last Year's Accomplishments
The FCHB sponsored, Risky Beginnings training was attended by 80 individuals including Public Health Home Visiting (PHHV) home visitors and early childhood providers.

FCHB staff cleaned, organized and summarized five years of PHHV data.

In April, 2008 the PHHV reassessment project was initiated. To date, FCHB staff and PHHV stakeholders and contractors, met for three, face-to-face meetings. As a result, seven workgroups were formed: data, funding formula, marketing, outcomes, program requirements, program training, and Targeted Case Management. Each workgroup met via telephone conference over the summer and presented recommendations to PHHV stakeholders at a face-to-face meeting in August.

FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee that developed the State of MT Intimate Partner Violence and Sexual Violence (IPV/SV) Prevention Plan. The staff member provided expertise about the studies in the U.S. finding an association between domestic violence, substance use, and smoking. Researchers hypothesize that smoking may act as a "stress reliever" in households that experience domestic violence.

FCHB funded 15 PHHV projects, two of which are located on one of Montana's seven Indian reservations. Enhanced PHHV services were provided to five of these sites and on an additional Indian reservation. Enhanced PHHV services included an additional team member, and a support specialist, who provided weekly home visits and intensive case management (ICM) to those women at the highest risk of substance use during pregnancy. Enhanced PHHV services are based on research indicating that 1) pregnant women who smoke cigarettes are nearly twice as likely to have a low-birth weight baby as women who do not smoke; 2) smoking slows fetal growth and increases the risk of premature delivery; 3) alcohol and illicit drugs can limit fetal growth and can cause birth defects; and 4) some drugs, such as cocaine, also may increase the risk of premature delivery.

FCHB provided standard training to PHHV providers. Topics included: an overview of the PHHV project; how to screen for depression using the Edinburgh Depression Screen, how to screen for alcohol use by using the T-ACE, a screening tool asking questions about: Tolerance, Annoyed, Cut Down and Eye-opener; tobacco cessation techniques; domestic violence using the American

College and OB/GYN Tool (ACOG); and the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social and Emotional (ASQSE) developmental screening tool.

FCHB staff traveled to three of Montana's Indian Reservations to assess interest in expanding PHHV services to new locations. Information gathered from these visits was used to write a Request for Proposal (RFP) for PHHV services on Indian reservations. One new PHHV project was funded on the Northern Cheyenne Reservation and the FCHB trained their staff on the PHHV requirements.

FCHB offered information on programs such as the Montana Tobacco Use Prevention Program (MTUPP) Quit Line, Women's Breast and Cervical Program, and the March of Dimes Prematurity Prevention materials to the PHHV and Fetal, Infant and Child Mortality Review (FICMR) programs.

The percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates decreased in 2008, although the reasons for such a substantial decrease are unknown. It may be useful to look at whether the 2008 very low birth weight deliveries had different characteristics that may relate to early indications of risk or access to facilities than very low birth weight births in previous years.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to fund PHHV/FASD Projects.				X
2. Promote Montana's tobacco quit line as a resource for PHHV/FASD projects.			X	
3. Collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 16 PHHV and 6 Enhanced PHHV projects, 3 of which are on one of the 7 Indian reservations, continue to be funded, with FCHB staff providing standardized training on the PHHV assessment tools to the local PHHV providers. The Enhanced Projects continue to include a support specialist who provides Intensive Case Management (ICM) to those women at highest risk of substance use during pregnancy.

FCHB continues coordinating the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. The report is on the FCHB website.

FCHB staff presented a summary of 2005-2007 PHHV data to PHHV providers.

FCHB participated on the DELTA statewide steering committee. Their State of MT Intimate IPV/SV prevention plan, which includes an implementation plan, was submitted to the CDC in April, 2009.

FCHB and MTUPP staff collaborated to provide tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

c. Plan for the Coming Year

All the PHHV and Enhanced PHHV sites will be monitored at least once by the FCHB staff. The sites will be checked for their compliance with program requirements and the FCHB staff will provide technical assistance, as needed.

FCHB will continue to fund the 17 PHHV/Enhanced PHHV programs, which will be encouraged to promote the Montana Tobacco Quit Line through information and referrals to their pregnant women and infant/family units. The PHHV sites will also be encouraged to refer their clients to other community programs, specific to their community, whose mission supports their PHHV program of supporting and promoting healthy pregnancy outcomes.

FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers. The iLinc technology will be implemented to decrease time spent traveling in an attempt to reach PHHV providers and other public health providers working with women and children across Montana.

FCHB will promote and coordinate training on Motivational Interviewing technique, for use by PHHV teams. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	85.5	86	85.4	85.9	84.5
Annual Indicator	82.6	83.1	82.4	82.1	71.3
Numerator	9513	9616	10302	10213	8982
Denominator	11514	11573	12499	12437	12595
Data Source					Live birth records, MT Office of Vital Statistics
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	73	74	75	75	75

Notes - 2008
2008 data for this measure should not be compared to previous years. The data source for this measure is the Montana Office of Vital Statistics and includes births to MT residents reported to the MT Office of Vital Statistics. The decrease in the timing when prenatal care relates to changes in the way the data are collected on the new birth record format implemented in 2008. Also, 6% of records reported "unknown" timing of prenatal care initiation, a large increase from the approximately 2% unknown reported in previous years.

Notes - 2007
The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. Data reflect births to Montana residents, and were updated for the July 15, 2009 grant submission.

Notes - 2006
The data source for this performance measure is the Office of Vital Statistics, Montana DPHHS. Data reflect births to Montana residents, regardless of whether they occurred in the state or elsewhere.

a. Last Year's Accomplishments
The FCHB sponsored, Risky Beginnings training was attended by 80 individuals including Public Health Home Visiting (PHHV) home visitors and early childhood providers.

FCHB staff cleaned, organized and summarized five years of PHHV data.

In April, 2008 the PHHV reassessment project was initiated. To date, FCHB staff and PHHV stakeholders and contractors, met for three, face-to-face meetings. As a result, seven workgroups were formed: data, funding formula, marketing, outcomes, program requirements, program training, and Targeted Case Management. Each workgroup met via telephone conference over the summer and presented recommendations to PHHV stakeholders at a face-to-face meeting in August.

FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee that developed the State of MT Intimate Partner Violence and Sexual Violence (IPV/SV) Prevention Plan. The staff member provided expertise about the studies in the U.S. finding an association between domestic violence, substance use, and smoking. Researchers hypothesize that smoking may act as a "stress reliever" in households that experience domestic violence.

FCHB funded 15 PHHV projects, two of which are located on one of Montana's seven Indian reservations. Enhanced PHHV services were provided to five of these sites and on an additional Indian reservation. Enhanced PHHV services included an additional team member, and a support specialist, who provided weekly home visits and intensive case management (ICM) to those women at the highest risk of substance use during pregnancy. Enhanced PHHV services are based on research indicating that 1) pregnant women who smoke cigarettes are nearly twice as likely to have a low-birthweight baby as women who do not smoke; 2) smoking slows fetal growth and increases the risk of premature delivery; 3) alcohol and illicit drugs can limit fetal growth and can cause birth defects; and 4) some drugs, such as cocaine, also may increase the risk of premature delivery.

FCHB provided standard training to PHHV providers. Topics included: an overview of the PHHV project; how to screen for depression using the Edinburgh Depression Screen, how to screen for alcohol use by using the T-ACE, a screening tool asking questions about: Tolerance, Annoyed,

Cut Down and Eye-opener; tobacco cessation techniques; domestic violence using the American College and OB/GYN Tool (ACOG); and the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social and Emotional (ASQSE) developmental screening tool.

FCHB staff traveled to three of Montana's Indian Reservations to assess interest in expanding PHHV services to new locations. Information gathered from these visits was used to write a Request for Proposal (RFP) for PHHV services on Indian reservations. One new PHHV project was funded on the Northern Cheyenne Reservation and the FCHB trained their staff on the PHHV requirements.

FCHB offered information on programs such as the Montana Tobacco Use Prevention Program (MTUPP) Quit Line, Women's Breast and Cervical Program, and the March of Dimes Prematurity Prevention materials to the PHHV and Fetal, Infant and Child Mortality Review (FICMR) programs.

MT adopted a new birth certificate in 2008. 2008 data on initiation of prenatal care should not be compared to data from previous years due to changes in the way the data are collected. Prenatal care initiation is now reported by date of first prenatal care visit (collected from the mother's prenatal care record), and a calculation is used to estimate the month or trimester of pregnancy when the first visit took place. Previously, prenatal care initiation was collected by asking the month of pregnancy when prenatal care began. Other states have experienced a similar drop in rates of early prenatal care initiation when the 2003 revisions to the US standard certificate of live birth were adopted (See NCHS' "Births: Final data for 2005"). Also, 6% of 2008 records have "unknown" timing of prenatal care initiation, a large increase from the approximately 2% reported in previous years. However, among those pregnancies with known timing of prenatal care initiation (11824), 75.9% reported starting prenatal care in the first trimester.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB will continue to support and monitor PHHV programs.			X	X
2. FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers.			X	X
3. The FCHB staff will collaborate with the Healthy Mothers, Healthy Babies, the March of Dimes Montana Chapter, Family Planning Programs and WIC providers to support prenatal care.		X		X
4. FCHB will continue to promote early access to prenatal care by facilitating a pregnant woman’s enrollment in Medicaid by assisting with the presumptive eligibility process, thus allowing her access early prenatal care.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 16 PHHV and 6 Enhanced PHHV projects, 3 of which are on one of the 7 Indian reservations, continue to be funded, with FCHB staff providing standardized training on the PHHV assessment tools to the local PHHV providers. The Enhanced Projects continue to include a support specialist who provides ICM to those women at highest risk of substance use during pregnancy.

FCHB continues coordinating the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. The report is on the FCHB website: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB staff presented a summary of 2005-2007 PHHV data to PHHV providers.

FCHB participated on the DELTA statewide steering committee. Their State of MT Intimate IPV/SV prevention plan, which includes an implementation plan, was submitted to the CDC in April 2009.

FCHB and MTUPP staff provided tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

c. Plan for the Coming Year

All the PHHV and Enhanced PHHV sites will be monitored at least once by the FCHB staff. The sites will be checked for their compliance with program requirements and the FCHB staff will provide technical assistance, as needed.

FCHB will continue to fund the 17 PHHV/Enhanced PHHV programs, which will be encouraged to promote the Montana Tobacco Quit Line through information and referrals to their pregnant women and infant/family units. The PHHV sites will also be encouraged to refer their clients to other community programs, specific to their community, whose mission supports their PHHV program of supporting and promoting healthy pregnancy outcomes.

FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers. The iLinc technology will be implemented to decrease time spent traveling in an attempt to reach PHHV providers and other public health providers working with women and children across Montana.

FCHB and PHHV project staff will continue to promote the importance of early and adequate prenatal care to pregnant women and women of childbearing age in Montana through home visits to pregnant women. The PHHV teams will continue to assess, refer and monitor the status of prenatal care through home visits

Partnerships with a number of entities will be continued. The FCHB staff will collaborate with the Healthy Mothers, Healthy Babies (HM/HB) Montana Coalition to distribute information through the HMHB clearinghouse that is related to the importance of early and adequate prenatal care; the March of Dimes Montana Chapter to focus on prematurity prevention; the Family Planning Programs in Montana to counsel and refer clients with positive pregnancy tests to early prenatal care and PHHV services, if appropriate; and WIC providers to refer pregnant clients to PHHV services and early prenatal care, if needed.

FCHB will continue to promote early access to prenatal care by facilitating a pregnant woman's enrollment in Medicaid by assisting with the presumptive eligibility process, thus allowing her access early prenatal care.

PHHV sites, without an electronic data reporting system, will be financially supported to purchase software that satisifies the PHHV Program's data requirement. Additionally, the FCHB will coordinate regional trainings that will include software installation and use. There will also be training on the required PHHV data elements, which include standard definitions determined by the PHHV Reassessment Project. The long term goal is for PHHV sites to electronically submit their data every six months.

FCHB staff will continue to participate on the DELTA statewide steering committee as it implements the Intimate Partner Violence and Sexual Violence Prevention Plan.

D. State Performance Measures

State Performance Measure 1: *Percent of unintended pregnancy among Title X clinic clients.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	52	63	62	62	61
Annual Indicator	64.6	64.0	64.0	71.5	56.6
Numerator	1200	1251	1281	1188	950
Denominator	1858	1955	2002	1661	1677
Data Source					Women's and Men's Health Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	61	60	60	60	60

Notes - 2008
The denominator is the total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies.

Notes - 2007
The denominator is total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies.

Notes - 2006
The denominator is total Title X clients receiving a positive pregnancy test. The numerator is the total of these clients with unintended pregnancies. Due to data collection changes this is an estimate.

a. Last Year's Accomplishments
Pregnancy prevention and birth control were identified as needs by adolescents and women, respectively, in the 2005 Maternal and Child Health Needs Assessment. The Women's and Men's Health Section (WMHS) of the Family and Community Health Bureau (FCHB) maintained contracts and provided technical assistance to 14 Delegate Agencies (DA) offering services in 27 locations serving all 56 counties in MT. These agencies assured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of family planning services and supplies. Go to: http://www.dphhs.mt.gov/PHSD/Women-Health/directory.shtml

In state fiscal year 2008, the Delegate Agencies served 26,828 women and men. It is estimated that family planning services prevented approximately 17,310 unintended pregnancies and 2,458 abortions during this time.

WMHS provided outreach materials and fact sheets on topics, such as the 24-hour toll-free hotline number that provides information on the nearest Family Planning Clinic, pregnancy prevention and family planning services, to county Offices of Public Assistance, Healthy Mothers Healthy Babies (HMHB), Public Health Home Visiting Programs (PHHV), WIC offices, 14 local Breast and Cervical Health Program sites (BCP), and Indian Health Services (IHS) as well as to the Delegate Agencies. See the attachment.

The Department of Public Health and Human Services (DPHHS) submitted the 1115 Medicaid Waiver to Centers for Medicare and Medicaid Services (CMS) so as to expand family planning services to low income women on July 1, 2008.

The Office of Population Affair's (OPA) additional special initiative funds provided Delegate Agencies with funding for male clinic services, HIV testing and counseling, satellite clinics, and outreach services for teen pregnancy prevention, and funds to increase access to highly effective contraceptives as well as emergency contraceptives.

The intra-uterine device (IUD) referral system continued to allow rural Delegate Agencies, without the capacity to provide IUD insertions, the ability to refer these clients to larger agencies. In Fiscal Year '08, 77 low income women received IUD's.

WMHS received Special Initiative funding from the Department of Health and Human Services (DHHS) Office of Population Affairs (OPA) that were distributed to Bridger Clinic for the Partners in Prevention Project. Bridger Clinic collaborated with several agencies to provide supplementary comprehensive sex education and family planning services to teen mothers and fathers and other at risk youth for teen pregnancy prevention.

The WMHS Health Education Specialist, a member of a Region VIII Regional Training Advisory Council (RTAC), participated in their yearly planning meeting for selecting DA's training topics. The RTAC reviewed the Region VIII Title X Programs' Training Needs Assessment, which is conducted bi-annually, and selected trainings that included education and clinical components. At the May 2008 Family Planning Conference a session was dedicated to adolescent counseling for clinicians.

The WMHS Health Education Specialist is a member of the State Family Planning Information and Education Committee (SPIEC), consisting of delegate agency staff, that meets yearly. At their 2008 meeting, the SPIEC reviewed and approved materials and identified priorities for all delegate agencies. The SPIEC identified Teen Pregnancy Prevention Month as a priority and continued to coordinate a statewide outreach campaign.

WMHS received a Title X Expansion Grant to increase patient numbers statewide. The grant supplemented all 14 Delegate Agencies ability to expand services in underserved communities targeting low income women and men, including adolescents. Each DA submitted a work plan with strategies to market, increase clinic or clinician hours, or expand service to outlying areas to increase their patient load. The first progress report is due April 15, 2009 with the goal of increasing patient numbers 10% by 2013, with the baseline of 26,853.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. WMHS continues to provide reproductive health services, technical assistance, and educational and outreach materials			X	X
2. Distribute an on-line newsletter for all the DAs				X
3. Meet and discuss materials and family planning priorities with the SPIEC.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
WMHS continues to provide reproductive health services, technical assistance, and educational and outreach materials to the 14 DAs and partners: HM/HB, PHHV sites, and WIC. See the attached map.

DPHHS continues monitoring the 1115 Medicaid Waiver submitted on 7/1/08 to Centers for Medicare and Medicaid Services (CMS)

As of April 19, 2009, the IUD referral system, permitting rural DAs to refer their clients to a larger DA has allowed 97 low income women access to an IUD and the program allowing qualified men and women to receive free sterilization has served 10 low-income men.

The Nurse Consultant continued to meet with RTAC, evaluating DAs and Region VIII Title X agencies training needs. The Family Planning Annual Training Conference held May 14-15, 2009 focused on adolescent, clinician, and front desk training.

The Health Education Specialist continues to meet and discuss materials and family planning priorities with the SPIEC.

OPA funding continues to support expanding male reproductive health services; the Bozeman Teen Outreach and Teen Pregnancy Prevention Project; for dispensing highly effective as well as emergency contraceptives; and for increasing services in underserved communities that target low income women, men, and adolescents.

WMHS created an on-line newsletter for all the DAs. The newsletter includes information on funding opportunities, upcoming trainings and events, updated reproductive health information and pertinent information for Title X agencies.

An attachment is included in this section.

c. Plan for the Coming Year
WMHS intends to contract with the 14 Delegate Agencies to provide reproductive health services, technical assistance, and educational and outreach materials to residents that represent all 56 counties in MT.

WMHS will work with and support Planned Parenthood in developing a statewide coalition for teen pregnancy prevention in Montana. One of the efforts of the coalition, in partnership with OPI, will be to train teachers on effective comprehensive sex education curriculums.

The State Family Planning Information and Education Committee (SPIEC), facilitated by the

WMHS Health Education specialist will continue their yearly meetings focusing on promoting Teen Pregnancy Prevention Month, Family Involvement Month, Sexual Health Awareness Month, and the "I Know" Campaign through statewide outreach campaigns.

WMHS Health Education specialist will continue to meet with the Regional Training Advisory Council to evaluate training needs for delegate agencies and Region VIII Title X agencies. The May 2010 conference will focus on topics identified by Title X agencies in the training needs assessment.

WMHS Health Education specialist will attend at least one reproductive health conference focusing on pregnancy prevention.

WMHS Program specialist will gather data on teen pregnancy rates in Montana and distribute information to local DAs on current rates and trends. The data will be distributed in a Teen Pregnancy Prevention interim report in fall 2009.

WMHS Health Education and Program Specialists will start coordinating efforts, with the assistance of the MCH epidemiology unit, to update the current Trends in Teen Pregnancies and Outcomes in Montana report for 1994-2008 in preparation for the release in 2010.

The WMHS Health Education Specialist will investigate on-line resources and other sources of current information that include unintended pregnancy prevention and share this information with the Delegate Agencies and other public health partners.

WMHS will continue to apply for Office of Population Affairs special funding for supplementing the Delegate Agency's budgets to purchase efficacious contraceptives. Efficacious contraceptives include those contraceptives that are more expensive than birth control pills: Nuva Ring, Ortho-Evra Patch, and the Intrauterine Contraceptive (IUC).

WMHS will contact and coordinate with Foster Care, TANF, WIC facilitators and other state agencies that work with youth to develop policies to provide education and training on family planning and reproductive health services to youth. Long term outcomes will include more at-risk teens receiving comprehensive sex education, more teens accessing family planning services, and ultimate goal to have an impact in reducing the rate of teen pregnancy and births in Montana.

State Performance Measure 2: *Percent of women who abstain from alcohol use in pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	98.3	98.5	98
Annual Indicator	97.0	97.0	96.8	97.2	97.3
Numerator	11203	11122	11988	11939	12109
Denominator	11554	11468	12388	12287	12446
Data Source					MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	98	98	98	98	99

Notes - 2008

The data source for this measure is live birth and fetal death records for events that occurred in Montana to Montana residents, as reported to the Montana Office of Vital Statistics. The numerator includes women who reported no alcohol use during pregnancy. The denominator includes all MT residents with a reported live birth or fetal death in Montana in 2008. Vital records data on alcohol use during pregnancy are based on self-report. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance.

Notes - 2007
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2007 and reported not drinking alcohol during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2007 and reported not drinking alcohol during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2007. Vital records data on alcohol use in pregnancy is based on self-report. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance.

Notes - 2006
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2006 and reported not drinking alcohol during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2006 and reported not drinking alcohol during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2006. Vital records data on alcohol use in pregnancy is based on self-report. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance.

a. Last Year's Accomplishments
The FCHB sponsored, Risky Beginnings training was attended by 80 individuals including Public Health Home Visiting (PHHV) home visitors and early childhood providers.

FCHB staff cleaned, organized and summarized five years of PHHV data.

In April, 2008 the PHHV reassessment project was initiated. To date, FCHB staff and PHHV stakeholders and contractors, met for three, face-to face meetings. As a result, seven workgroups were formed: data, funding formula, marketing, outcomes, program requirements, program training and Targeted Case Management. Each workgroup met via telephone conference over the summer and presented recommendations to PHHV stakeholders at a face-to-face meeting in August.

FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee that developed the State of MT Intimate Partner Violence and Sexual Violence (IPV/SV) Prevention Plan.

FCHB funded 15 PHHV projects, two of which are located on one of Montana's seven Indian reservations. Enhanced PHHV services were provided to five of these sites and on an additional Indian reservation. Enhanced PHHV services included an additional team member, and a support specialist, who provided weekly home visits and intensive case management (ICM) to those women at the highest risk of substance use during pregnancy. Enhanced PHHV services are based on research indicating that 1) pregnant women who smoke cigarettes are nearly twice as likely to have a low-birthweight baby as women who do not smoke; 2) smoking slows fetal growth and increases the risk of premature delivery; 3) alcohol and illicit drugs can limit fetal growth and can cause birth defects; and 4) some drugs, such as cocaine, also may increase the risk of premature delivery.

FCHB provided standard training to PHHV providers. Topics included: an overview of the PHHV project; how to screen for depression using the Edinburgh Depression Screen, how to screen for alcohol use by using the T-ACE, a screening tool asking questions about: Tolerance, Annoyed, Cut Down and Eye-opener; tobacco cessation techniques; domestic violence using the American College and OB/GYN Tool (ACOG); and the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social and Emotional (ASQSE) developmental screening tool.

FCHB staff traveled to three of Montana's Indian Reservations to assess interest in expanding PHHV services to new locations. Information gathered from these visits was used to write a Request For Proposal (RFP) for PHHV services on Indian reservations. One new PHHV project was funded on the Northern Cheyenne Reservation and the FCHB trained their staff on the PHHV requirements.

FCHB offered information on programs such as the Montana Tobacco Use Prevention Program (MTUPP) Quit Line, Women's Breast and Cervical Program, and the March of Dimes Prematurity Prevention materials to the PHHV and Fetal, Infant and Child Mortality Review (FICMR) programs.

FCHB staff and one local staff attended the FASD Center for Excellence Building FASD State Systems (BFSS) meeting for states in Colorado Springs, CO. The meetings are convened annually and are intended to increase awareness of, and interest in, FASD prevention and treatment. These BFSS meetings are designed to facilitate the creation and enhancement of comprehensive systems of care for FASD. The meetings are part of the Center's response to its legislative mandate to provide technical assistance to communities developing systems of care.

The percent of women who report no alcohol use during pregnancy continues to be high, at about 97% or a little higher. The question about alcohol use during pregnancy remained on the revised Montana birth record implemented in 2008, even though it is not a part of the latest U.S. Standard Certificate of Live Birth (2003 revision). The question asks about alcohol use during pregnancy, but does not ask about the frequency or amount of alcohol consumed. Similar to cigarette smoking, birth record data is expected to underestimate the number of people who drink during pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB will continue to fund the PHHV/Enhanced PHHV programs which will be encouraged to promote abstinence from drinking alcohol at any time during pregnancy.			X	X
2. FCHB will provide training to each PHHV site on the use of the 5P's screening tool for alcohol and illicit drug use.				X
3. FCHB will collect data on alcohol use and cessation during pregnancy on each PHHV client from all of the PHHV sites.				
4. FCHB will promote and coordinate training on Motivational Interviewing technique, for use by PHHV teams.		X		X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 16 PHHV and 6 Enhanced PHHV projects, 3 of which are on one of the 7 Indian reservations, continue to be funded, with FCHB staff providing standardized training on the PHHV assessment tools to the local PHHV providers.

FCHB continues to facilitate the PHHV reassessment project, resulting in the 5P's tool to screen for alcohol and illicit drug use during pregnancy asking about use by Parents, Peers, Partner, Past and Pregnancy being implemented at the PHHV sites.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. The report is on the FCHB website: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB staff presented a summary of 2005-2007 PHHV data to PHHV providers.

FCHB participated on the DELTA statewide steering committee. Their State of MT Intimate IPV/SV prevention plan, which includes an implementation plan, was submitted to the CDC in April, 2009.

FCHB collaborated with MTUPP staff for providing tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

FCHB coordinated the enhanced PHHV program evaluator's presentation to the 6 projects, summarizing program data and outcomes from 2006 to 2008.

FCHB staff and one local staff attended the FASD Center for Excellence Building FASD State Systems (BFSS) meeting for states in May, 2009 in Albuquerque, New Mexico.

c. Plan for the Coming Year

FCHB will continue to fund the 17 PHHV/Enhanced PHHV programs which will be encouraged to promote abstinence from drinking alcohol at any time during pregnancy, through information and referrals to community resources who will work with the pregnant women and infant/family units. Women who are at particularly high risk of drinking during pregnancy and having a child with an FASD include: women with substance abuse or mental health problems; women who have already had a child with an FASD; recent drug users; smokers; women who have multiple sex partners; and recent victims of abuse and violence.

FCHB will provide training to each PHHV site on the use of the 5P's screening tool for alcohol and illicit drug use.

FCHB will collect data on alcohol use and cessation during pregnancy on each PHHV client from all of the PHHV sites.

All the PHHV and Enhanced PHHV sites will be monitored at least once by the FCHB staff. The sites will be checked for their compliance with program requirements and the FCHB staff will provide technical assistance, as needed related to alcohol, tobacco and other drug use during pregnancy.

FCHB will promote and coordinate training on Motivational Interviewing technique, for use by PHHV teams. Motivational Interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

State Performance Measure 4: *Percent of state fetal/infant/child deaths reviewed for preventability by local review teams.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	95	95	95	96	92
Annual Indicator	92.8	90.2	88.7	90.2	87.2
Numerator	155	185	165	156	156
Denominator	167	205	186	173	179
Data Source					Mortality reviews and vital statistics
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	88	88	88	88	88

Notes - 2008
As of 2008, the data reported for this measure are one year behind, to allow for more complete reporting and tracking of trends. Fetal, infant, and child mortality review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by a delayed death certificate or other circumstances related to the death. 156 FICMR reviews for 2007 had been submitted as of July of 2009. The denominator is the number of fetal, infant, and child deaths that occurred in Montana or to Montana residents in 2007 and were reported to the Montana Office of Vital Statistics. This definition of the denominator was standardized for the 2009 block grant submission; previous years do not necessarily use the same denominator. The objective was adjusted to be more appropriate for the change in data reporting.

Notes - 2007
The numerator is 2007 reviews completed as of July 2009. Although a few more reviews may be submitted for 2007, the year is nearly complete. Fetal, Infant, and Child Mortality Review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by other circumstances relating to the death. The denominator reflects fetal, infant and child deaths (through age 17 years) that occured in MT to MT residents, as reported to the MT Office of Vital Statistics.

Notes - 2006
The numerator represents the final number of reviews for 2006, and was updated for the July 2009 submission. Fetal, Infant, and Child Mortality Review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by other circumstances relating to the death. The denominator reflects fetal, infant and child deaths (through age 17 years) that occured in MT to MT residents, as reported to the MT Office of Vital Statistics.

a. Last Year's Accomplishments
The Fetal Infant Child Mortality Review (FICMR) mission statement continues to identify, address, and potentially decrease the numbers of preventable fetal, infant, and child deaths in the state of Montana. The FCHB state FICMR Coordinator assisted local FICMR team members to accurately identify preventable deaths and to develop community based mechanisms to decrease the incidence of preventable deaths in the target population.

FCHB collaborated with Healthy Mothers/Healthy Babies (HMHB) on their "Safe Sleep Program" by sharing information with WIC, local public health agencies, and the Public Health Home Visiting/Fetal Alcohol Spectrum Disorder (PHHV/FASD) Projects. Public Health Home visiting staff provided information about the HMHB "Safe Sleep Program" during their home visits with the

clients. Eight of the sixteen PHHV/FASD Projects referred their clients for services in the past year.

FCHB continued to sustain the FICMR activities, including training opportunities; the collection and analysis of 2005-2006 FICMR data for the next report; providing assistance to local FICMR teams in accurately identifying preventable deaths; and serving as a resource for local public health agencies efforts in reducing the number of preventable deaths in their communities.

The State FICMR Coordinator completed an email survey to all local coordinators asking for their input on what was working and what needed to be improved with the FICMR program. Several coordinators requested a FICMR new-coordinator training to provide information on conducting a mortality review in their community. Another request was for a review on death certificates.

The State FICMR Coordinator offered support to local FICMR coordinators needing assistance in filling out the FICMR data collection tool.

The percent of deaths reviewed continues to be around 90%. Fetal, infant, and child mortality review teams may review deaths as long as 6-12 months after the event, and in some cases completion and submission of reviews may be delayed even longer by a delayed death certificate, litigation, turnovers in staff, or other circumstances related to the death. Therefore, the 2008 data actually reflect 2007 reviews. In the past, the MCHBG review had been based on extremely under-reported data, and the same data was then included in the TVIS reporting for Montana because no update was available before the September submission. The result was that Montana's rate appeared extremely, artificially low for the latest reporting year. With the 2008 data, the decision was made to report data one year behind so that reporting is more complete.

The denominator used for reporting this measure was also changed with the 2008 data. As of the 2009 submission, the denominator for this measure will be all fetal, infant, and child (17 and under) deaths reported in Montana or to Montana residents, as reported to the MT Office of Vital Statistics. Because FICMR reviews are sometimes conducted for resident deaths that occur out-of-state, as well as deaths of out-of-state residents that occur in Montana, neither MT resident nor MT occurrent deaths alone were considered to be a good match for the numerator. While a few deaths reviewed by FICMR teams never have a death certificate reported to MT vital stats, there are also some deaths reported to Montana vital stats that are never reviewed. FICMR teams are informed of all fetal, infant, and child deaths with a death certificate that are reported to the MT Office of Vital Statistics. Previous years were not changed to reflect this because the objectives for those years were set using different data. However, the objectives for all years from 2009 on were reset, with the anticipation that the new denominator will result in a slightly lower indicator. Among MT occurrent deaths for 2007, 97.5% were reviewed. Among resident deaths for 2007, 90.2% of deaths were reviewed. Among resident and occurrent deaths, 87.2% were reviewed. This is an increase from 84.2% of resident and occurrent deaths reviewed in 2006.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. FCHB and HMHB will continue their joint coordination of the Safe Sleep Project, with the FCHB ensuring that PHHV and FICMR staff continue their client referrals.			X	X
2. The FCHB staff will continue to support state and community FICMR prevention efforts through twice a year educational meetings and trainings and by being available as a resource.				X
3. FCHB will promote prevention strategies statewide through distribution of the FICMR Data Report which includes Community Prevention activities.				X

4. The State FICMR Coordinator will meet at least quarterly with the Injury Prevention Coordinator to collaborate on prevention strategies and activities.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
FCHB continues to sustain FICMR activities with several training opportunities. The FICMR coordinator training included FICMR review basics, death certificate information and a Mock Case Review for 13 attendees.

The new State FICMR Coordinator trained 30 local FICMR coordinators on determining preventability of deaths and conducted a mock review. There was also discussion on the review tool, keeping local team members involved and an open discussion on prevention activities and lessons learned.

The MCH Epidemiologist analyzed the 2005-06 FICMR data and assisted with the final report. The report was distributed to the local FICMR coordinators and is available online on the FCHB website.

The FICMR Emergency Medical Services for Children (EMSC) state coordinators attended a National Symposium of State Leaders in Maternal Child Health, Injury Prevention and Child Death Review Keeping Kids Alive, May 20-22, 2009 in Washington DC. Montana specific information, i.e. graduated drivers license, car seat safety education, check stations, and information related to the review of youth fatalities from motor vehicle accidents was highlighted on their poster board presentation.

FCHB staff attended training, April 29, 2009, on Native American SIDS prevention sponsored by Healthy Native Babies. The information was shared with locals at FICMR coordinator meeting in June 2009.

c. Plan for the Coming Year
FCHB and HMHB will continue their joint coordination of the Safe Sleep Project, with the FCHB ensuring that PHHV and FICMR staff continue their client referrals.

The FCHB staff will continue to support state and community FICMR prevention efforts through twice a year educational meetings and trainings and by being available as a resource via phone, email or in person contacts. The State Coordinator will share current journal articles and information received from national list-serves related to infant and child death prevention, with the local coordinators via email.

The State Coordinator will explore the feasibility of incorporating I-Linc or regional meetings for local FICMR coordinator trainings and meetings. This will allow for the potential of increased participation in meetings because of decreased travel time and time away from their offices. The importance of the local FICMR meetings is that they allow local coordinators an opportunity to network, share prevention activities and collaborate on lessons learned with their peers, thereby improving the sense of teamwork.

FCHB staff will provide training updates to local FICMR coordinators on how to accurately complete the FICMR data reporting form to ensure consistency in all reviews. These training

updates will be included in the local coordinator biannual meetings. The trainings will include case examples of incorrect form completion and mock reviews, as well as a review of the 2005-2006 FICMR Data Report which includes community prevention activities.

The MCH Epidemiologist will work with FCHB staff on a process to review FICMR data on an annual basis, facilitating earlier identification of preventable deaths and earlier implementation of prevention activities. The FCHB will also assist the local FICMR teams in understanding their data findings and incorporating them into community level prevention activities.

FCHB will promote prevention strategies statewide through distribution of the 2005-2006 FICMR Data Report which includes Community Prevention activities. The report will also be available on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-resource.shtml

The State FICMR Coordinator will collaborate with local coordinators and the MCH Epidemiologist to review and revise the current FICMR data collection tool to ensure that the data collected is in its most usable form. The State Coordinator will work with State Information Technology staff to update the state FICMR database.

The State FICMR Coordinator will continue to attend the quarterly EMSC Advisory Meetings to act as a resource for FICMR information and to relay pertinent prevention information back to the local coordinators.

The State FICMR Coordinator will meet at least quarterly with the Injury Prevention Coordinator to collaborate on prevention strategies and activities. Prevention activities and ideas will be shared with the local coordinators via email or during trainings.

State Performance Measure 5: *Percent of Medicaid eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	33	23	20.4	19.5	26
Annual Indicator	22.6	23.3	24.5	26.0	25.6
Numerator	14707	15374	15066	16793	16378
Denominator	65079	66078	61369	64620	64071
Data Source					Medicaid EPSDT Form16
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	28	29	30	31

Notes - 2008
The source for this data is EPSDT. It is run on the FFY 2008.
An updated Medicaid data were published on March 3rd, 2009 for previous years. The released data did not reflect any changes in the numerator or denominator for FFY 2006 and FFY 2007.

Notes - 2007
The source for this data is EPSDT. It is run on the FFY 2007.

Notes - 2006
The source for this data is EPSDT. It is run on the FFY 2006. CZ

a. Last Year's Accomplishments
The Oral Health Education Specialist (OHES) maintained contact with the Montana Oral Health Alliance (MOHA) members. The MOHA 5-Year Strategic Plan was updated as fluctuating membership and participation allowed. The MOHA plan continues to address the importance of early intervention.

The MOHA's Community Based Prevention Work Group completed their work on the oral health message, which in turn was submitted for Department approval, which was granted. The OHES began researching the cost of printing the posters as well as compiling a stakeholders' distribution list.

The Oral Health/Food Stamp (OH/FS) Project supported the work of 18 Community School Readiness Teams and the Open Wide, an online training for Head Start and child care providers, which is provided through a partnership with Public Health and Safety Division's Training and Communication Center (TCC). The School Readiness Teams offered oral health educational materials at their sponsored parent meetings and collected oral health data from a School Readiness Communities Oral Health Questionnaire. (Attached) For calendar year 2008, Open Wide training had been completed by 17 providers caring for 595 children.

The Bureau assisted the Health Resources and Services Administration (HRSA), Office of Performance Review (OPR) in the planning of the State Strategic Partnership Session meeting held in Helena, MT on June 20, 2008. The 40 plus participants identified four action steps that were discussed during the meeting. These action steps were addressed for the coming year: 1) Develop stronger collaborations across the state to increase access to oral health services; 2) Increase funding for health centers to expand their services and strengthen their clinical staff; 3) Develop a continuing education course for dentists and physicians that provides the latest evidence base for oral health care treatment of children ages 0 to 3 years; and 4) Provide additional training for dental providers and Medicaid beneficiaries regarding the Montana Early Periodic Screening, Diagnosis, and Treatment (EPSDT) dental program. HRSA provided ongoing technical assistance, as well as financial support, during the completion of the action steps.

The Bureau initiated conversations with the MT Primary Care Association (MT PCA), MT Dental Association (MDA) and Medicaid staff for developing a Request for Proposal (RFP) for the Community Health Centers (CHC) to offer the MT Access to Baby Child Dentistry (ABCD) Partnership Program with funding from the Oral Health/Food Stamp partnership beginning in January 2008. The FCHB Epidemiology Unit was involved with designing the ABCD data collection tool which would be used for future oral health grant submissions, as well as satisfy the reporting requirement for the Oral Health/Food Stamp partnership. The MT ABCD program is modeled after the state of Washington's ABCD Program. For more information go to: http://www.abcd-dental.org/

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide monthly technical assistance conference calls for the ABCD program				X
2. Continue partnership with the MT Primary Care Association and the MT Dental Association				X
3. Participate on the Interdisciplinary Training Committee and the MT Oral Health Alliance teams				X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities
Due to funding changes and staff turnover, the Oral Health Work Plan was reassessed in early 2009 and the position has been reformatted as a Health Education Specialist whose duties will include promoting oral health education activities.

All the Oral Health Summit action steps were implemented by blending HRSA, MDA, MT PCA, and FCHB financial resources. ABCD Training was offered to 77 dental health professions in May, 2009. MT Medicaid is supporting the new ABCD practice standard. See the Attachment.

Quarterly meetings were held with the MT PCA to discuss oral health related needs.

Five CHCs began offering the ABCD Program on April 1, 2009, with the first monthly training provided in June, 2009.

The FCHB submitted an oral health grant, Improving Children's Oral Health in MT, which includes funding for continuing the ABCD Partnership Projects, with an award date of 9/1/09.

Open Wide training received continuing education approval from the MT Early Childhood Project and it averages about 15 providers completing the training each month.

The OH/FS Project supported the cost associated with producing 5000 posters with the approved oral health message.

The Medicaid Dental Provider Manual, which includes the new fee schedule as of July 1, 2009 is anticipated to be completed in July 2009.

An attachment is included in this section.

c. Plan for the Coming Year
Through December 31, 2009, funding is available for the MT ABCD Partnership Program; thus allowing for the continuation of the monthly technical assistance conference calls. The CHCs are required to submit progress/data reports in August and November 2009. The Epidemiology Unit will analyze the data and a final report will be written by the FCHB with an anticipated release date of spring 2010.

MT Medicaid will continue to offer additional ABCD trainings throughout the year and as the ABCD caries risk assessment data becomes available it will be utilized to evaluate the program's effectiveness. There will be continued collaboration with MDA and the FCHB on policy development. The new CHIPRA legislation, requiring Medicaid to display a list of DDS who are accepting new Medicaid kids under 21, will be posted and updated as needed.

The Health Education Specialist will be charged with participating on the Interdisciplinary Training Committee that was initiated by Sharon Kott, Montana Area Health Education Center (MT AHEC). The general purpose of this committee is similar to the MT Oral Health Alliance; therefore, the Family Health Advisory Council will discuss the continuation of the MOHA or if it would be a better use of resources to support the Interdisciplinary Training Committee's work.

The Health Education Specialist will finalize the distribution of the oral health message posters.

If the oral health grant, Improving Children's Oral Health in MT, is approved, it would provide funding for continuing the work begun with the Oral Health/Food Stamp Program's MT ABCD Partnership Project. The grant also would fund a contractual agreement with a public or private agency to implement a community based sealant program.

The FCHB will continue their quarterly meetings with the MT Primary Care Association.

State Performance Measure 6: *Percent of pregnant women who abstain from cigarette smoking.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	82	83	81.6	81.6	82
Annual Indicator	80.6	81.0	80.6	81.8	81.2
Numerator	9308	9284	9980	10048	10110
Denominator	11554	11468	12388	12287	12446
Data Source					MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	82	82.5	82.5	83

Notes - 2008
The data source for this measure is live birth and fetal death records for events that occurred in Montana to Montana residents, as reported to the Montana Office of Vital Statistics. The numerator includes women who reported no cigarette smoking during pregnancy. The denominator includes all MT residents with a reported live birth or fetal death in Montana in 2008. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking during pregnancy are based on self-report.

Notes - 2007
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2007 and reported not smoking during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2007 and reported not smoking during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2007. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking in pregnancy is based on self-report.

Notes - 2006
Numerator and denominator data are from the Montana Office of Vital Statistics. The numerator includes the number of resident women who experienced a live birth in MT in 2006 and reported not smoking during pregnancy, plus the number of resident women who experienced a fetal death in MT in 2006 and reported not smoking during pregnancy. Denominator data includes all resident women who experienced a live birth or a fetal death in MT in 2006. Only events that occurred in the state to MT residents are included, as reporting of stillbirths or fetal deaths and smoking data from other states may not be consistent with Montana's pregnancy surveillance. Vital records data on smoking in pregnancy is based on self-report. This indicator was updated for the July 15, 2008 submission.

a. Last Year's Accomplishments
The FCHB sponsored, Risky Beginnings training was attended by 80 individuals including Public Health Home Visiting (PHHV) home visitors and early childhood providers.

FCHB staff cleaned, organized and summarized five years of PHHV data.

In April, 2008 the PHHV reassessment project was initiated. To date, FCHB staff and PHHV stakeholders and contractors, met for three, face-to-face meetings. As a result, seven workgroups were formed: data, funding formula, marketing, outcomes, program requirements, program training, and Targeted Case Management. Each workgroup met via telephone conference over the summer and presented recommendations to PHHV stakeholders at a face-to-face meeting in August.

FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee that developed the State of MT Intimate Partner Violence and Sexual Violence (IPV/SV) Prevention Plan. The staff member provided expertise about the studies in the U.S. finding an association between domestic violence, substance use, and smoking. Researchers hypothesize that smoking may act as a "stress reliever" in households that experience domestic violence.

FCHB funded 15 PHHV projects, two of which are located on one of Montana's seven Indian reservations. Enhanced PHHV services were provided to five of these sites and on an additional Indian reservation. Enhanced PHHV services included an additional team member, and a support specialist, who provided weekly home visits and intensive case management (ICM) to those women at the highest risk of substance use during pregnancy. Enhanced PHHV services are based on research indicating that 1) pregnant women who smoke cigarettes are nearly twice as likely to have a low-birthweight baby as women who do not smoke; 2) smoking slows fetal growth and increases the risk of premature delivery; 3) alcohol and illicit drugs can limit fetal growth and can cause birth defects; and 4) some drugs, such as cocaine, also may increase the risk of premature delivery.

FCHB provided standard training to PHHV providers. Topics included: an overview of the PHHV project; how to screen for depression using the Edinburgh Depression Screen, how to screen for alcohol use by using the T-ACE, a screening tool asking questions about: Tolerance, Annoyed, Cut Down and Eye-opener; tobacco cessation techniques; domestic violence using the American College and OB/GYN Tool (ACOG); and the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social and Emotional (ASQSE) developmental screening tool.

FCHB staff traveled to three of Montana's Indian Reservations to assess interest in expanding PHHV services to new locations. Information gathered from these visits was used to write a Request for Proposal (RFP) for PHHV services on Indian reservations. One new PHHV project was funded on the Northern Cheyenne Reservation and the FCHB trained their staff on the PHHV requirements.

FCHB offered information on programs such as the Montana Tobacco Use Prevention Program (MTUPP) Quit Line, Women's Breast and Cervical Program, and the March of Dimes Prematurity Prevention materials to the PHHV and Fetal, Infant and Child Mortality Review (FICMR) programs.

The percent of women who report smoking during pregnancy on the birth record has remained fairly consistent over the past several years. Smoking during pregnancy tends to be more common among younger women. The birth record data is believed to be an underreport of the actual rate of smoking during pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. FCHB will conduct site visits to monitor PHHV programs.			X	X
2. FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers.			X	X
3. FCHB will promote and coordinate training for use by PHHV teams.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The 16 PHHV and 6 Enhanced PHHV projects, 3 of which are on one of the 7 Indian reservations, continue to be funded, with FCHB staff providing standardized training on the PHHV assessment tools to the local PHHV providers. The Enhanced Projects continue to include a support specialist who provides Intensive Case Management to those women at highest risk of substance use during pregnancy.

FCHB continues coordinating the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breastfeeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. See: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB staff presented a summary of 2005-2007 PHHV data to PHHV providers.

FCHB participated on the DELTA statewide steering committee. Their State of MT Intimate IPV/SV prevention plan, which includes an implementation plan, was submitted to the CDC in April, 2009.

FCHB and MTUPP staff provided tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

c. Plan for the Coming Year

All the PHHV and Enhanced PHHV sites will be monitored at least once by the FCHB staff. The sites will be checked for their compliance with program requirements and the FCHB staff will provide technical assistance, as needed.

FCHB will continue to fund the 17 PHHV/Enhanced PHHV programs, which will be encouraged to promote the Montana Tobacco Quit Line through information and referrals to their pregnant women and infant/family units. The PHHV sites will also be encouraged to refer their clients to other community programs, specific to their community, whose mission supports their PHHV program of supporting and promoting healthy pregnancy outcomes.

FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers. The iLinc technology will be implemented to decrease time spent traveling in an attempt to reach PHHV providers and other public health providers working with women and children across Montana.

FCHB will promote and coordinate training on Motivational Interviewing technique, for use by PHHV teams. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

State Performance Measure 7: *Rate of firearm deaths among youth aged 5-19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7.2	7	8	8	6
Annual Indicator	6.3	8.5	6.4	5.4	4.3
Numerator	12	16	12	10	8
Denominator	189830	189318	188200	186887	185954
Data Source					MT Office of Vital Statistics and census estimates
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	4.2	4.2	4.1	4.1	4

Notes - 2008
As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2006-2008. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2006-2008, based on mid-year census estimates.

Notes - 2007
As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2005-2007. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2005-2007, based on mid-year census estimates. These data were updated for the July 2009 submission.

Notes - 2006
As of the 2005 data, this indicator is calculated using 3-year moving averages. The numerator is the average number of deaths due to a firearm for Montana resident youth ages 5 through 19 in 2004-2006. The denominator is the estimated average number of youth aged 5 through 19 years in Montana in 2004-2006, based on mid-year census estimates. These data were updated for the July 2009 submission.

a. Last Year's Accomplishments
FCHB shared the State FICMR Team's prevention strategies, such as gun safety education and using gun locks, with 30 local FICMR Coordinators at one of the yearly trainings. Additionally, the State Fish Wildlife and Parks (FWP) Department demonstrated the gun lock use and discussed firearm safety.

The partnership continued with the State Injury Prevention Coordinator, housed in the Emergency Medical Services (EMS) and Trauma System Section Bureau whereby gun safety information, i.e. state statistics; prevention tips for kids, adults, and parents; locations for free or low-cost trigger locks; and links to downloadable educational games were included on the state's Emergency Medical System /Trauma webpage: http://www.dphhs.mt.gov/ems/emsother/linkspages/links.html

The Public Health Home Visiting (PHHV) home visitors provided gun safety and safe firearm storage educational materials during home visits to approximately 1200 clients. The education was provided through educational handouts obtained in their communities or through a face-to-face discussion between the PHHV visitor and client.

The Statewide Suicide Prevention Plan recommended increasing firearm safety measures by providing gun locks and hunter safety education. FCHB shared this message with the 12 Youth Suicide Prevention (YSP) Projects and ensured that each project had information promoting the awareness of proper and safe storage of firearms for their communities.

Federal funding cuts resulted in FCHB being unable to replace staff members responsible for coordinating the Statewide Youth Suicide Prevention Project. The FCHB provided financial and technical assistance to the 12 YSP Projects through 9/30/08 at which time the statewide YSP efforts were transitioned to the Statewide Suicide Prevention Coordinator (SSPC).

The Statewide Suicide Prevention Coordinator collaborated with five county health departments located in Gallatin, Lewis and Clark, Yellowstone, Missoula, and Cascade Counties and the Montana-Wyoming Tribal Leaders Council (MT/WYTLC) Planting Seeds of Hope (PSOH) to distribute gun locks with prevention message.

The rate of firearm deaths in Montana among youth 5-19 has decreased in recent years. Firearms are a common means for suicide in Montana and are often the means for homicide deaths, particularly among older children. Among deaths in 2005 and 2006 that were reviewed by local FICMR teams, 16 involved firearms. These deaths are generally found to have been preventable by the FICMR teams, and lack of supervision and easily accessible firearms were factors that contributed to the deaths. In the majority of the deaths the gun was not stored in a locked cabinet, and in over half of the cases the firearm did not have a trigger lock.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The FCHB staff will continue to support state and community FICMR prevention efforts through twice a year educational meetings and trainings and by being available as a resource.				X
2. FCHB will promote prevention strategies statewide through distribution of the FICMR Data Report which includes Community Prevention activities.				X
3. The State FICMR Coordinator will meet at least quarterly with the Injury Prevention Coordinator to collaborate on prevention strategies and activities.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The FCHB continues to sustain FICMR activities with several training opportunities. New FICMR coordinator training, for those who have not conducted a FICMR review, included FICMR review basics, death certificate information and a Mock Case Review for 13 attendees.

The 2005-06 FICMR data was analyzed and a FICMR report was written. The report, which highlighted evidenced-based best practices and prevention activities in Montana including accidental and intentional firearm deaths, was distributed to the local FICMR coordinators and is available online on the FCHB website.

One new partner is Emergency Medical Services for Children (EMSC), of the Chronic Disease Prevention and Health Promotion Bureau (CDPHPB). The EMSC coordinator works cooperatively with outside agencies and healthcare teams to implement and evaluate injury prevention programs. The FCHB works with the EMSC Coordinator incorporating preventable infant/child injuries, identified by local FICMR teams, into the State Injury Prevention Strategic Plan.

A second partnership is with Karl Rosston, who was hired in December 2007 as the statewide Suicide Prevention Coordinator. FCHB has worked providing technical assistance and guidance to Mr. Rosston during the transition of youth suicide prevention activities this year.

c. Plan for the Coming Year
The FCHB staff will continue to support state and community FICMR prevention efforts through twice a year educational meetings and trainings and by being available as a resource via phone, email or in person contacts. The State Coordinator will share current journal articles and information received from national list-serves related to infant and child death prevention, with the local coordinators via email.

The State Coordinator will explore the feasibility of incorporating I-Linc or regional meetings for local FICMR coordinator trainings and meetings. This will allow for the potential of increased participation in meetings because of decreased travel time and time away from their offices. The importance of the local FICMR meetings is that they allow local coordinators an opportunity to network, share prevention activities and collaborate on lessons learned with their peers, thereby improving the sense of teamwork.

FCHB staff will provide training updates to local FICMR coordinators on how to accurately complete the FICMR data reporting form to ensure consistency in all reviews. These training updates will be included in the local coordinator biannual meetings. The training updates will include case examples of incorrect form completion and mock reviews, as well as a review of the 2005-2006 FICMR Data Report which includes community prevention activities.

The MCH Epidemiologist will work with FCHB staff on a process to review FICMR data on an annual basis, facilitating earlier identification of preventable deaths and earlier implementation of prevention activities. The FCHB will also assist the local FICMR teams in understanding their data findings and incorporating them into community level prevention activities.

FCHB will promote prevention strategies statewide through distribution of the 2005-2006 FICMR Data Report which includes Community Prevention activities. This report is reviewed at a local coordinators training and prevention activities from across the state are discussed. The report will also be available on the FCHB website http://www.dphhs.mt.gov/PHSD/family-health/ficmr/ficmr-resource.shtml

The State FICMR Coordinator will collaborate with local coordinators and MCH Epidemiologist to review and revise the current FICMR data collection tool to ensure data collected is in the most

usable form. The State Coordinator will work with State Information Technology staff to update the state FICMR database.

The State FICMR Coordinator will continue to attend the quarterly EMSC Advisory Meetings to act as a resource for FICMR information and to relay pertinent prevention information, specifically gun safety and suicide prevention information, back to the local coordinators.

The State FICMR Coordinator will meet at least quarterly with the Injury Prevention Coordinator to collaborate on prevention strategies and activities. Prevention activities and ideas will be shared with the local coordinators via email or during trainings.

State Performance Measure 8: *Percent of low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			6	6	6
Annual Indicator	7.7	6.7	7.3	7.2	7.4
Numerator	881	772	911	895	931
Denominator	11514	11573	12499	12437	12595
Data Source					MT Office of Vital Statistics
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	7	7	6.9	6.9	6.8

Notes - 2008
The numerator includes low birth weight (<2500 grams) births to Montana residents that occurred in Montana, as reported to the Montana Office of Vital Statistics. The denominator includes the number of live births to Montana residents that occurred in Montana.

Notes - 2007
The numerator includes low birth weight (<2500 grams) births to Montana residents, as reported to the Montana Office of Vital Statistics. The denominator includes the number of live births to Montana residents. The 2007 data were updated for the July 2009 submission.

Notes - 2006
The Montana Office of Vital Statistics is the data source for this performance measure. The numerator includes low birth weight (<2500 grams) births to Montana residents (regardless of place of occurrence). The denominator includes the number of live births to Montana residents (regardless of place of occurrence). The data for this indicator were updated with final vital statistics data in 2008.

a. Last Year's Accomplishments
The FCHB sponsored, Risky Beginnings training was attended by 80 individuals including Public Health Home Visiting (PHHV) home visitors and early childhood providers.

FCHB staff cleaned, organized and summarized five years of PHHV data.

In April, 2008 the PHHV reassessment project was initiated. To date, FCHB staff and PHHV stakeholders and contractors, met for three, face-to-face meetings. As a result, seven workgroups were formed: data, funding formula, marketing, outcomes, program requirements, program training, and Targeted Case Management. Each workgroup met via telephone

conference over the summer and presented recommendations to PHHV stakeholders at a face-to-face meeting in August.

FCHB staff participated on the Domestic Violence Prevention Enhancement and Leadership Through Alliances (DELTA) statewide steering committee that developed the State of MT Intimate Partner Violence and Sexual Violence (IPV/SV) Prevention Plan. The staff member provided expertise about the studies in the U.S. finding an association between domestic violence, substance use, and smoking. Researchers hypothesize that smoking may act as a "stress reliever" in households that experience domestic violence.

FCHB funded 15 PHHV projects, two of which are located on one of Montana's seven Indian reservations. Enhanced PHHV services were provided to five of these sites and on an additional Indian reservation. Enhanced PHHV services included an additional team member, and a support specialist, who provided weekly home visits and intensive case management (ICM) to those women at the highest risk of substance use during pregnancy. Enhanced PHHV services are based on research indicating that 1) pregnant women who smoke cigarettes are nearly twice as likely to have a low-birthweight baby as women who do not smoke; 2) smoking slows fetal growth and increases the risk of premature delivery; 3) alcohol and illicit drugs can limit fetal growth and can cause birth defects; and 4) some drugs, such as cocaine, also may increase the risk of premature delivery.

FCHB provided standard training to PHHV providers. Topics included: an overview of the PHHV project; how to screen for depression using the Edinburgh Depression Screen, how to screen for alcohol use by using the T-ACE, a screening tool asking questions about: Tolerance, Annoyed, Cut Down and Eye-opener; tobacco cessation techniques; domestic violence using the American College and OB/GYN Tool (ACOG); and the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire Social and Emotional (ASQSE) developmental screening tool.

FCHB staff traveled to three of Montana's Indian Reservations to assess interest in expanding PHHV services to new locations. Information gathered from these visits was used to write a Request for Proposal (RFP) for PHHV services on Indian reservations. One new PHHV project was funded on the Northern Cheyenne Reservation and the FCHB trained their staff on the PHHV requirements.

FCHB offered information on programs such as the Montana Tobacco Use Prevention Program (MTUPP) Quit Line, Women's Breast and Cervical Program, and the March of Dimes Prematurity Prevention materials to the PHHV and Fetal, Infant, and Child Mortality Review (FICMR) programs.

Montana's low birth weight rate appears to have been gradually increasing for at least the past 8 years. The low birth weight rate in 2002 was 6.6 and the rate for 2008 is 7.4.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue to fund PHHV/FASD Projects.				X
2. Promote Montana's tobacco quit line as a resource for PHHV/FASD projects.			X	
3. Collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers.			X	X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities
The 16 PHHV and 6 Enhanced PHHV projects, 3 of which are on one of the 7 Indian reservations, continue to be funded, with FCHB staff providing standardized training on the PHHV assessment tools to the local PHHV providers. The Enhanced Projects continue to include a support specialist who provides ICM to those women at highest risk of substance use during pregnancy.

FCHB continues coordinating the PHHV reassessment project and developed a logic model for project evaluation and a standard set of data elements. Stakeholders identified health improvement priority areas for pregnant women and infants: prenatal care utilization; alcohol, tobacco and other drug use; nutrition; stress; exclusive breast feeding for first 6 months of age; prevention of child abuse and neglect; immunizations; and early identification and intervention for infants at risk for developmental delays.

By using 2006 data, the FCHB developed a PHHV Report summarizing key program outcomes. The report is on the FCHB website: http://www.dphhs.mt.gov/PHSD/family-health/home-visiting/home-visiting-index.shtml

FCHB staff presented a summary of 2005-2007 PHHV data to PHHV providers.

FCHB participated on the DELTA statewide steering committee. Their State of MT Intimate IPV/SV prevention plan, which includes an implementation plan, was submitted to the CDC in April, 2009

FCHB and MTUPP staff provided tobacco cessation training to 41 PHHV and other public health staff in three regions across Montana.

c. Plan for the Coming Year
All the PHHV and Enhanced PHHV sites will be monitored at least once by the FCHB staff. The sites will be checked for their compliance with program requirements and the FCHB staff will provide technical assistance, as needed.

FCHB will continue to fund the 17 PHHV/Enhanced PHHV programs, which will be encouraged to promote the Montana Tobacco Quit Line through information and referrals to their pregnant women and infant/family units.

FCHB will collaborate with MTUPP, to provide at least one regional training on tobacco cessation strategies for pregnant women (based on need) for PHHV providers. The iLinc technology will be implemented to decrease time spent traveling in an attempt to reach PHHV providers and other public health providers working with women and children across Montana.

FCHB will promote and coordinate training on Motivational Interviewing technique, for use by PHHV teams. Motivational interviewing is a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence.

State Performance Measure 9: *Percent of Montana public middle and secondary schools that include comprehensive sexuality education as part of their health curriculum.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective				63	63
Annual Indicator			62.6	62.6	62.6
Numerator			107	107	107
Denominator			171	171	171
Data Source					Women's and Men's Health Program
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	70	70	70	70

Notes - 2008
The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey has not been repeated and no future suveys are planned at this time.

Notes - 2007
The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey included only high schools, therefore middle schools are not included in this first year of data reporting, although the intent is to include them in future surveys. 20 (11.7%) of the 171 high schools did not repsond to the survey.

The data used for this indicator suggest that 25% of the schools reporting comprehensive sexuality education as a part of their curriculum actually only teach about contraceptive failure rates. The definition of comprehensive sexuality education used for this performance measure will be reviewed. As a result, schools that only teach about contraceptive failure rates may not be included in the numerator in the future, which would result in a lower indicator. ahb df

Notes - 2006
New SPM for the MCH BG 08 Application. The source of these data are the 2002-2003 Sex Education Telephone Questionnaire conducted by Planned Parenthood. The survey included only high schools, therefore middle schools are not included in this first year of data reporting, although the intent is to include them in future surveys. 20 (11.7%) of the 171 high schools did not repsond to the survey.

The data used for this indicator suggest that 25% of the schools reporting comprehensive sexuality education as a part of their curriculum actually only teach about contraceptive failure rates. The definition of comprehensive sexuality education used for this performance measure will be reviewed over the coming year. As a result, schools that only teach about contraceptive failure rates may not be included in the numerator in the future, which would result in a lower indicator. ahb df

a. Last Year's Accomplishments
The Women's and Men's Health Section (WMHS), of the Family and Community Health Bureau (FCHB), Health Education Specialist partnered with many different agencies for the purpose of coordinating the work on implementing comprehensive sexuality education into the Montana public middle and secondary school curriculums. Some of the partnerships included the Joint Committee for Healthy Kids (JCHK) comprised of state employees from the Department of Public Health and Human Services (DPHHS) and the Office of Public Instruction (OPI); the 14 Delegate Agencies (DA) that provide family planning and education services to all 56 counties; the Missoula Adolescent Pregnancy, Parenting, and Prevention Services (MAPPS); the Montana Partnership for Sex Education; and several partnerships within DPHHS, including the HIV/STD

Section Supervisor.

The 14 DA assured that women and men of reproductive age, including adolescents, had access to comprehensive reproductive health care, educational information, and services that included how to prevent unintended pregnancy. The agencies' sliding fee schedules, based on family size and income, also ensured the affordability of family planning services and supplies. http://www.dphhs.mt.gov/PHSD/Women-Health/directory.shtml

The WMHS Health Education Specialist presented information about teen pregnancy rates, best practices, and comprehensive sexuality education at the Montana Family Planning Annual Meeting in May 2008 There were over 45 participants in attendance.

In March 2008, Bill Traverner from Planned Parenthood Federation of America presented the workshop Sex Ed 101 attended by over 100 participants who were teachers, school administrators, counselors, health educators, and nurses.

WMH also provided additional training opportunities for public health and family planning staffs that included: "Field Guide to Sex Ed" at the May 2008 Spring Public Health Conference; and "A Snapshot of Montana Youth" at the Annual Family Planning Conference.

The Health Education Specialist facilitated the October 2007 "Let's Talk/ Family Involvement Months" and the May 2008 National Teen Pregnancy Prevention Month's activities which incorporated prevention messages that encouraged comprehensive sexuality education.

The Health Education Specialist assisted with writing the report: Teen Pregnancy Prevention Month: Adolescent Health Viewed Through Teen Pregnancy featured in the May 2008 Montana Public Health: Prevention Opportunities Under the Big Sky. www.dphhs.mt.gov/PHSD

The Program Specialists provided training on Teen Pregnancy Prevention at the fall 2008 Montana Public Health Association Conference which included: state data released May 2008, risk and protective factors, statewide indicators, best practices, and skills building for communities.

The WMHS Program and Health Education Specialists and the FCHB epidemiologist were key resources for the collection of teen pregnancy data included in the updated 2008 Trends in Teen Pregnancies and Their Outcomes in Montana fact sheet. The Trends in Teen Pregnancies and Their Outcomes in Montana From 1991 - 2005 Report was finalized in May 2008 and distributed across the state to family planning and other health related agencies. The 2006 data showed that the teen pregnancy rate continues to drop for 15-19 year olds and is currently 47.8/1,000 representing a 21.8% reduction from the 1995 rate of 61.2/1,000. http://www.dphhs.mt.gov/PHSD/Women-Health/documents/teenpregnancyreport.pdf

Due to staff turnover the Health Education Specialist was unable to attend and present information about comprehensive sexuality education at the 2008 Fall Parent Teacher Association conference in Great Falls, MT.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. presented information about teen pregnancy rates, best practices, and comprehensive sexuality education at the Montana Family Planning Annual Meeting				X
2. Provide additional training opportunities for public health and family planning staffs				X

3. WMHS Education Specialist will coordinate Let's Talk/ Family Involvement Month in October and National Teen Pregnancy Prevention Month in May to the Delegate Agencies.			X	X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Program Specialist coordinated the October 2008 "Let's Talk/ Family Involvement Month" toolkit and the Health Education Specialist coordinated the May 2009 National Teen Pregnancy Prevention Month toolkit. Each DA received the toolkit and coordinated activities by incorporating the prevention message that encourages comprehensive sexuality education.

WMHS surveyed Delegate Agencies to determine if the electronic toolkits are meeting their needs as well as to gather information as to how to improve future tool kits. The results indicated that the toolkits were greatly appreciated and helpful for outreach efforts in the local communities.

During the 2009 legislative session the Healthy Youth Sex Education bill, seeking matching funding to improve teacher training and curriculum resources to improve teen pregnancy prevention and STI education in Montana schools was introduced. Although the bill did not pass, additional efforts to implement age-appropriate and medically accurate comprehensive sex education curriculum into Montana public schools is being pursued. Planned Parenthood is in the beginning stages of developing a statewide coalition for teen pregnancy prevention in Montana. One of the efforts of the coalition, in partnership with OPI, will be to train teachers on effective comprehensive sex education curriculums.

c. Plan for the Coming Year
WMHS Education Specialist will continue to coordinate and provide electronic toolkits for Let's Talk/ Family Involvement Month in October and National Teen Pregnancy Prevention Month in May to the Delegate Agencies.

WMHS will work with and support Planned Parenthood in developing a statewide coalition for teen pregnancy prevention in Montana. One of the efforts of the coalition, in partnership with OPI, will be to train teachers on effective comprehensive sex education curriculums. The National Campaign to Prevent Teen and Unintended Pregnancy has offered both funding and technical assistance to host this meeting with identified key stakeholders from across the State. Partners from OPI, WIC, TANF, Medicaid, Foster Care, and Juvenile Justice, along with many other health professionals, will be invited to attend. The goal of this meeting will be to form a strategic plan to implement evidence-based teen pregnancy prevention activities in Montana.

WMHS will contact and coordinate with Foster Care, TANF, WIC facilitators and other state agencies that work with youth to develop policies to provide education and training on family planning and reproductive health services to youth. Long term outcomes will include more at-risk teens receiving comprehensive sex education, more teens accessing family planning services, and ultimate goal to have an impact in reducing the rate of teen pregnancy and births in Montana.

E. Health Status Indicators

Introduction
The HSIs provide a description and overview of the resident MCH population in the state. They are an opportunity for the state to review and consider rates on crucial MCH issues, such as low birth weight, very low birth weight and deaths due to various causes. They provide some perspective over time on trends in the data, as well as an opportunity to assess how the data have been collected and reported in the past and consider how changes in data systems and limitations in the data sources may affect the quality of what is reported.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.7	6.7	7.3	7.2	7.4
Numerator	881	772	911	895	931
Denominator	11514	11573	12499	12437	12595
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Notes - 2006
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
/2010/ See State Performance Measure 8 for a description of activities.

Montana's low birth weight rate appears to have been gradually increasing. The low birth weight rate in 2000-2002 was 6.6 and the rate for 2006-2008 is 7.3. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	5.8	5.4	5.6	5.6	5.8
Numerator	651	609	676	671	706
Denominator	11135	11278	12092	12034	12203
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Notes - 2006
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
/2010/ See State Performance Measure 8 for a description of activities.

Montana's singleton low birth weight rate appears to have been gradually increasing. The singleton low birth weight rate in 2000-2002 was 5.2 and the rate for 2006-2008 is 5.7. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.1	1.0	1.2	1.2	1.1
Numerator	127	114	149	144	144
Denominator	11514	11573	12499	12437	12595
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Notes - 2006
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
/2010/ See State Performance Measure 8 for a description of activities.

Montana's very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The very low birth weight rate in 2000-2002 was 1.1 and the rate for 2006-2008 is 1.2. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	0.9	0.9	0.9	0.9	0.9
Numerator	103	98	106	103	111
Denominator	11135	11278	12092	12034	12203
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Notes - 2007
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence. The data were updated for the July 2009 submission.

Notes - 2006
The data source is the Montana Office of Vital Statistics. These data include births that occured to MT residents, regardless of the place of occurrence.

Narrative:
/2010/ See State Performance Measure 8 for a description of activities.

Montana's singleton very low birth weight rate appears to have been gradually increasing, although the change is fairly small. The singleton very low birth weight rate in 2000-2002 was 0.8 and the rate for 2006-2008 is 0.9. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	11.8	10.2	10.7	9.6	11.8
Numerator	21	18	19	17	21

Denominator	178212	175610	177741	177688	178508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2007
2007 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2006
2006 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to unintentional injury among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
/2010/ Montana's death rate due to unintentional injury among children 14 and younger has remained fairly stable. Unintentional injury is a leading cause of death for Montanans of all ages. Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Approximately 80% of the 2005-2006 unintentional injury deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, at least 90% of unintentional injury deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use by a caregiver, poor or inadequate supervision, and lack of use of available safety measures such as seatbelts or helmets.

In addition, as of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	5.6	5.7	5.6	5.6	6.2
Numerator	10	10	10	10	11

Denominator	178212	175610	177741	177688	178508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2007
2007 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2006
2006 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 14 years and younger, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
/2010/ Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6-12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes.

Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience.

In the majority of the 2005-2006 deaths the child was in a passenger vehicle, although the reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles.

As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and

graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	46.3	35.0	43.1	43.2	43.4
Numerator	63	48	59	59	59
Denominator	136135	137200	136834	136424	136045
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15-24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2005 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2007
2007 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged 15 through 24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2006 data, this indicator is reported as a 3-year moving average due to the small number of events.

Notes - 2006
2006 data were updated for the July 2009 submission. The numerator is from the Montana Office of Vital Statistics and includes deaths due to motor vehicle incidents among Montana residents aged aged 15 through 24 years, regardless of the place of occurrence. The denominator is from the census estimates (May 2009 version). As of the 2006 data, this indicator is reported as a 3-year moving average due to the small number of events.

Narrative:
/2010/ Motor vehicle deaths are a leading cause of death for Montanans of all ages. While the death rate due to motor vehicle deaths is similar to other leading causes among young children, motor vehicles start to emerge as the primary cause of death among children 6-12. Among older teens and young adults motor vehicle deaths far outpace the other leading causes.

Local Fetal, Infant, and Child Mortality Review teams review deaths throughout the state to determine the preventability of the deaths and identify state, local, and community-level opportunities for prevention. Almost 80% of the 2005-2006 motor vehicle deaths in Montana or to Montana residents were reviewed by FICMR teams. Among the 2005-2006 deaths reviewed, 95% of motor vehicle deaths were determined to be preventable. Factors that might have contributed to the deaths include alcohol or drug use, lack of seat belt and child safety seat use, inattentive and reckless driving, and driver's inexperience.

In the majority of the 2005-2006 deaths the child was in a passenger vehicle, although the reviewed deaths also included pedestrians, ATVs, bicycles, and motorcycles.

As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on deaths due to intentional and unintentional injuries, and motor vehicle deaths in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	137.3	160.4	169.7	118.4	159.6
Numerator	230	284	301	211	287
Denominator	167463	177051	177413	178268	179844
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

2008 data are preliminary. The numerator for this indicator is from the state trauma registry. The trauma registry only includes severe injuries, and not all hospitals report their data to the registry, so the reported rate is believed to be significantly lower than the actual rate of nonfatal injuries. The denominator is the census estimate of children 14 years and younger in 2008 (May 2009 version).

Notes - 2007

The numerator for this indicator is from the state trauma registry. The trauma registry only includes severe injuries, and not all hospitals report their data, so this rate is believed to be significantly lower than the actual rate of nonfatal injuries. One large hospital did not submit data for 2007. The denominator is the census estimate of children 14 years and younger in 2007 (May 2009 version). The 2007 data were updated for the July 2009 submission.

Notes - 2006

The numerator for this indicator is from the state trauma registry. The trauma registry only includes severe injuries, and not all hospitals report their data, so this rate is believed to be significantly lower than the actual rate of nonfatal injuries. The denominator is the census estimate of children 14 years and younger in 2006 (May 2009 version). The 2006 data were updated for the July 2009 submission.

Narrative:

/2010/ The current data source for this indicator is the state trauma registry. The registry only includes severe injuries and does not include data from all hospitals. The indicator reported is considered to be a substantial underestimate of the actual rate of nonfatal injuries. This data source is not a good indication of trends, as the data quality can change from year to year. For instance, in 2007 one of the large hospitals in the state did not report any data to the registry.

A complete source of data for this indicator is not available in Montana. Hospital discharge data reporting is not mandatory and does not include emergency department data. The hospital discharge data that are available do not in most cases include the ecodes required to assess the types of injuries treated. A bill introduced in the 2009 Montana legislature to make hospital discharge data reporting mandatory did not pass. However, a statewide injury prevention program was established, which will increase the focus on injuries and is expected to assist in improving the quality of hospital discharge data.

A variety of injury prevention activities take place at the state and local levels, such as safety awareness education, Safe Kids/Safe Communities programs, and other activities targeted through various programs. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	482.0	452.4	433.1	398.3	363.6
Numerator	859	801	767	710	654
Denominator	178212	177051	177112	178268	179844
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Data Source is from MT Highway Patrol provided on July 8, 2009.

Notes - 2007
Source: MT DOT
RR
Update denominator on July 08, 2009 used data from US Census

Notes - 2006
Numerator data are from MT Department of Transportation. Denominator data are from census estimates for 2006. Hospital discharge data recently became available to the state and may be a source of data, or comparison data, for future reporting on this indicator. DF

Narrative:
/2010/ Data were provided by the MT Highway Patrol. There has been a decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple

public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving.

As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	2,344.7	2,220.1	2,273.7	2,150.2	1,910.2
Numerator	3192	3046	3114	2912	2593
Denominator	136135	137200	136959	135429	135746
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
Source of data from MT Highway Patrol provided on July 8, 2009.

Notes - 2007
Source: MT DOT
Updated denominator on July 8, 2009 from US Census.

Notes - 2006
Numerator data are from the MT Department of Transportation. Denominator data are from census estimates. Hospital discharge data recently became available to the state and may be a source of data, or comparison data, for future reporting on this indicator. DF

Narrative:
/2010/ Data were provided by the MT Highway Patrol. There has been a decline in the motor vehicle crashes among young children in the past few years. The change coincides with the implementation of graduated driver licensing. There have also been multiple public education campaigns and other activities to increase child safety seat and seat belt usage and reduce drunk driving.

As of the 2009 state legislative session, a statewide injury prevention program was established, which will increase the focus on intentional and unintentional injuries, and motor vehicle incidents in particular.

A variety of prevention activities take place at the state and local levels, including support for legislation such as a primary seatbelt law (not currently passed in Montana) and

graduated drivers licensing (currently required in Montana), as well as public service announcements and improved road safety. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	24.2	20.1	22.1	24.4	28.7
Numerator	823	660	720	794	926
Denominator	33992	32773	32551	32488	32209
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 15-19 years of age in 2008 (May 2009 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Notes - 2007
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2007. The denominator is from census estimates of Montana resident females 15-19 years of age in 2007 (May 2009 version). The data were updated for the July 2009 submission.

Notes - 2006
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2006. The denominator is from census estimates of Montana resident females 15-19 years of age in 2006 (May 2009 version). The data were updated for the July 2009 submission.

Narrative:
/2010/ The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in actual cases. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	7.0	7.2	7.7	7.8	8.4
Numerator	1046	1062	1140	1158	1249
Denominator	149597	148088	147904	148335	148909
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2008
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2008. The denominator is from census estimates of Montana resident females 20-44 years of age in 2008 (May 2009 version). The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in cases.

Notes - 2007
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2007. The denominator is from census estimates of Montana resident females 20-44 years of age in 2007 (May 2009 version). The data were updated for the July 2009 submission.

Notes - 2006
The source for the numerator is the STD Surveillance Database, STD MIS, from calendar year 2006. The denominator is from census estimates of Montana resident females 20-44 years of age in 2006 (May 2009 version). The data were updated for the July 2009 submission.

Narrative:
/2010/ The increase in the rate for 2008 is believed to be due to improved case reporting and an increase in the number of sites that reported test results, not because of an increase in actual cases. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	12773	10608	124	1317	98	14	612	0
Children 1 through 4	48341	39909	741	5383	371	51	1886	0
Children 5 through 9	58294	48679	1033	5937	449	59	2137	0
Children 10 through 14	60436	51831	831	5388	477	64	1845	0
Children 15 through 19	66597	57520	642	6237	419	51	1728	0
Children 20 through 24	69149	60728	582	5932	561	38	1308	0
Children 0 through 24	315590	269275	3953	30194	2375	277	9516	0

Notes - 2010
Source is 2007 Census estimates for MT, from downloaded "State by Age, Sex, Race, and Hispanic origin" file (5 race groups) http://www.census.gov/popest/datasets.html

Narrative:
/2010/ The data source for this indicator is census estimates. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	12210	609	0
Children 1 through 4	45611	2730	0
Children 5 through 9	54911	3364	0
Children 10 through 14	57596	2814	0
Children 15 through 19	64031	2550	0
Children 20 through 24	66929	2199	0
Children 0 through 24	301288	14266	0

Notes - 2010
Source is 2007 Census estimates for MT, from downloaded "State by Age, Sex, Race, and Hispanic origin" file (5 race groups) http://www.census.gov/popest/datasets.html

Narrative:
/2010/ The data source for this indicator is census estimates. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	9	5	0	3	0	0	1	0
Women 15 through 17	363	241	1	105	0	1	10	5
Women 18 through 19	943	661	6	219	9	4	36	8
Women 20 through 34	9899	8380	34	1113	76	16	173	107
Women 35 or older	1337	1209	7	77	23	2	9	10
Women of all ages	12551	10496	48	1517	108	23	229	130

Notes - 2010

Narrative:

/2010/ The data source for this indicator is live birth records from the Montana Office of Vital Statistics. 2008 data are preliminary. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	8	1	0
Women 15 through 17	346	17	0
Women 18 through 19	894	49	0
Women 20 through 34	9572	327	0
Women 35 or older	1301	36	0
Women of all ages	12121	430	0

Notes - 2010

Narrative:
/2010/ The data source for this indicator is live birth records from the Montana Office of Vital Statistics. 2008 data are preliminary. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	87	72	0	13	0	0	2	0
Children 1 through 4	12	8	0	2	0	0	2	0
Children 5 through 9	11	9	0	2	0	0	0	0
Children 10 through 14	16	14	0	2	0	0	0	0
Children 15 through 19	46	37	1	6	1	0	0	1
Children 20 through 24	82	61	0	15	0	0	3	3
Children 0 through 24	254	201	1	40	1	0	7	4

Notes - 2010

Narrative:

/2010/ The data source for this indicator is death records from the Montana Office of Vital Statistics. 2008 data are preliminary. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	84	3	0
Children 1 through 4	11	1	0
Children 5 through 9	11	0	0
Children 10 through 14	16	0	0
Children 15 through 19	45	1	0
Children 20 through 24	80	2	0
Children 0 through 24	247	7	0

Notes - 2010

Narrative:
/2010/ The data source for this indicator is death records from the Montana Office of Vital Statistics. 2008 data are preliminary. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	242716	211072	498	18301	1909	743	10193	0	2008
Percent in household headed by single parent	24.0	22.6	0.0	39.1	0.0	0.0	0.0	0.0	2008
Percent in TANF (Grant) families	2.3	1.1	21.7	17.7	0.5	1.3	0.0	0.0	2008
Number enrolled in Medicaid	64489	43450	844	17227	312	0	0	2656	2008
Number enrolled in SCHIP	22756	17864	158	2009	158	0	0	2567	2008
Number living in foster home care	2566	1512	73	915	2	2	0	62	2008

Number enrolled in food stamp program	21558	16523	163	4782	60	30	0	0	2008
Number enrolled in WIC	28466	19081	134	4942	41	47	4150	71	2008
Rate (per 100,000) of juvenile crime arrests	5435.6	5238.7	6927.3	7810.0	3324.5	0.0	0.0	296.0	2008
Percentage of high school drop-outs (grade 9 through 12)	5.2	4.4	6.1	11.5	3.3	6.1	0.0	6.5	2008

Notes - 2010
Source is the Current Population Survey Table Creator. CPS sample sizes in Montana are too small to accurately represent the number of children under 18 in single parent families by race. For example, there were only two African Americans interviewed in 2007. No inferences should be made based on these indicators. Because of the sample size issues, only percentages for whites and Native Americans (Montana's two primary race categories) are reported.

The numerator is the number of TANF participants averaged over 12 months during FFY 08. The denominator is 2008 census estimates using race categories.

Data Source: Medicaid data pulled on June 13, 2009. Medicaid combines Asian and Pacific Islander into one race category.
The number from Medicaid for "Asian or Pacific Islander" was entered in the BG application under "Asian" and zero (0) was entered under "Native Hawaiian or other Pacific Islander'"
Ethnicity is collected as a part of race, so data for people reported as Hispanic ethnicity with no race were entered under "Other and unknown."
Data are provisional.

Data Source: SCHIP data pulled on June 13, 2009. SCHIP combines Asian and Pacific Islander into one race category. The number from SCHIP for "Asian or Pacific Islander" was entered under "Asian" and zero (0) was entered under "Native Hawaiian or other Pacific Islander'"
Ethnicity is collected as a part of race, so data for people reported as Hispanic ethnicity with no race were entered under "Other and unknown."
Data are provisional.

Data source is the SNAP program. Data are final.

Data Source: WIC Program data pulled on April 7, 2009.

Data Source: MT Board of Crime Controlled pulled on May 7, 2009.

Data Source: OPI Enrollment and Drop Out Report Published on May 2009 for School Year 2007-2008.

Data source is the Child and Family Services Division of MT DPHHS.

Narrative:

/2010/ The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races.

For these reasons, the data for HSI 09A and B are considered estimates, and the summary below focuses on the total numbers reported for 2007 and 2008 instead of comparing numbers by race and ethnicity. This is a general assessment of participation in the following situations as reported in the block grant, and may not match what the programs themselves report.

From 2007 to 2008. . .

The overall census estimates of children 0-19 in Montana increased.

The estimates of the percent of children in single parent households decreased.

The percent of children in TANF families stayed about the same.

The number of children enrolled in Medicaid increased.

The number of children enrolled in SCHIP increased.

The number of children living in foster home care increased.

The number of children enrolled in the food stamp program decreased.

The number of children enrolled in WIC increased.

The rate of juvenile crime arrests decreased.

During the 2007-08 school year there was an increase in the percentage of drop outs from grades 9-12 compared to previous school years. This increase was due to improved dropout data collection procedures, including the new student information system (AIM) and increased emphasis placed on dropout data with regard to federal accountability requirements for public high schools.

Although the Current Population Survey (CPS) is the only source of data on the percent of children in a household headed by a single parent, the sample size for Montana is so small that it does not always provide valid estimates. During a discussion with the U.S Census Bureau about the CPS estimates for Montana, they recommended not using it as a data source for this measure. However, as it is the only data source available on single parent households, the data are reported for white and American Indian only, as these are two largest population groups (by race) in the state. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	234359	12067	0	2008

Percent in household headed by single parent	0.0	0.0	100.0	2008
Percent in TANF (Grant) families	2.3	2.1	0.0	2008
Number enrolled in Medicaid	61833	2652	4	2008
Number enrolled in SCHIP	20189	552	2015	2008
Number living in foster home care	2303	157	106	2008
Number enrolled in food stamp program	20971	587	0	2008
Number enrolled in WIC	26555	1840	71	2008
Rate (per 100,000) of juvenile crime arrests	5007.7	3364.5	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	5.1	6.5	0.0	2008

Notes - 2010
Source is the Current Population Survey Table Creator. CPS sample sizes in Montana are too small to accurately represent the number of children under 18 in single parent families by race and ethnicity. For example, there were only two African Americans interviewed in 2007. No inferences should be made based on these indicators. Because of the sample size issues, percentages are not reported by ethnicity.

The numerator is the number of TANF participants averaged over 12 months during FFY 08. The denominator is 2008 census estimates using ethnicity categories

Data Source: Medicaid data pulled on June 13, 2009.

Data Source: SCHIP data pulled on June 13, 2009.

Data provided by the Montana SNAP program.

Data Source: WIC Program data pulled on April 7, 2009.

Data Source: MT Board of Crime Controlled pulled on May 7, 2009.

Data Source: OPI Enrollment and Drop Out Report Published on May 2009 for School Year 2007-2008.

Data provided by the Child and Family Services Division of MT DPHHS.

Narrative:
/2010/ The programs that provide the data reported above have very different ways of collecting and reporting the data and do not all have standard categories of race and ethnicity. Data from the programs are often updated and cleaned throughout subsequent years, and so they may not all be final. Census estimates for Montana are often based on very small sample sizes, particularly for specific races. For these reasons, the data for HSI 09A and B are considered estimates. For additional discussion of this indicator, see Health Status Indicator 09A. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	88424

Living in urban areas	136270
Living in rural areas	110171
Living in frontier areas	0
Total - all children 0 through 19	246441

Notes - 2010
Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition of the National Center for Frontier Communities. The total population of youth 0-19 in those counties is 126,922 (52% of all 0-19 year olds in the state). Likewise there are 119,519 youth age 0-19 (or 48% of the total) living in non-frontier counties in the state.

Narrative:
/2010/ Estimates of children living in frontier areas are not included in the chart because frontier is not a category used by the census and is measured differently than rural/urban. To avoid duplication, it was not included. However, 49 counties in Montana are considered "Frontier" using the definition of the National Center for Frontier Communities (the National Center for Frontier Communities designates frontier counties using a weighted matrix of population density, distance in miles to a service/market center and travel time in minutes. More information is available at http://www.frontierus.org/documents/consensus.htm). The total population of youth 0-19 in those counties is 126,922 (52% of all 0-19 year olds in the state). Likewise there are 119,519 youth age 0-19 (or 48% of the total) living in non-frontier counties in the state. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	939097.0
Percent Below: 50% of poverty	5.0
100% of poverty	13.0
200% of poverty	33.0

Notes - 2010
Source: U.S. Census Bureau, Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Narrative:
/2010/ The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total

Children 0 through 19 years old	242716.0
Percent Below: 50% of poverty	6.0
100% of poverty	17.0
200% of poverty	42.0

Notes - 2010
Source: U.S. Census Bureau, Current Population Survey Table Creator (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html)

Narrative:
/2010/ The data source for this measure is the U.S. Census Bureau, Current Population Survey Table Creator. //2010//

F. Other Program Activities

Although mentioned elsewhere in this document, the importance of continuing to develop and refine the public health system and its capacity to support the delivery of the core functions and essential services of public health is worth emphasizing. Due to the rural/frontier nature of much of the state, we depend upon a public health workforce that is overburdened and under funded. In order to maximize the health of the public, and specifically the health of the MCH population, it is important that state level efforts continue to focus on supporting linkages and encouraging efficient delivery of services. A focus on population-based services is also key, with MCH continuing to struggle with its perceived role as a safety net provider of services otherwise not available or funded. The efforts of the Public Health Improvement Bureau and the public health informatics section will continue to help educate and support the workforce, and to improve and streamline reporting in order to decrease the burden on local contractors.

Reviewer questions asked for an examination of the low birth weight (LBW) incidence in Montana. A review of the existing data revealed that the appears to be a trend in the incidence of LBW births in Montana. Low birth weight, defined as births less than 2500 grams, is a standard indicator of perinatal health at both the state and federal levels. In response to this concern, a low birth weight trend analysis was performed on aggregate state data for the years 1995 to 2004, stratified by year and race. Using the Cochran-Armitage test for trend for the years in question regardless of race, there appeared to be a significant positive linear trend for the occurrence of low birth weight events in the state. Further investigation into the trend revealed though Native American populations were 16% more likely to have a low birth weight baby than Caucasian populations, however, they were not the cause of the positive linear trend, with noticeable highs and lows apparent for multiple years. The Caucasian population's variability over time was the significant cause of the positive linear trend seen in the analysis, rising approximately 30% since 1995.

In addition, strategic planing will be a focus during the remainder of 2005 and 2006. Further prioritization of health needs will occur using the priorities identified by stakeholders throughout the state and the involvement of FCHB Advisory Council Members and staff.

/2008/ The FCHB five sections continued their work on developing their respective work plans which in turn have been incorporated into the Bureau's strategic plan which is attached to this application. The Montana Oral Health Alliance resumed their meetings and completed Montana's Oral Health 5 Year Strategic Plan which formed the basis for the Targeted State MCH Oral Health Service Systems Grant Program 2007 application. The Oral Health Alliance will continue to meet and refine the Strategic Plan this coming year.

The FCHB Advisory Council continued to be involved with identifying priorities. As noted elsewhere, the Governor's Office has replaced the FCHB Advisory Council with the Family Health Committee, with Governor Appointments expected to be made in the Fall of 2007

A portion of the State Systems Development Initiative (SSDI) grant supported an assessment of the Public Health and Safety Division's information systems and data reporting requirements, which includes Maternal Child Health (MCH) data collection. This assessment was completed by Pete Kitch of KIPHS Inc. and the recommendation is that the Bureau uses the Business Process Analysis (BPA) to analyze how MCH currently works with their stakeholders (i.e. local health department officials). This process will include examining how work is currently being completed and "rethinking" on how things should work in determining the information needed to meet federal grant requirements. A committee, consisting of Bureau members and stakeholders will use this methodology as a way to determine the best solution for selecting a proper information system. It is anticipated that completing the BPA will help increase the state's and local's data collection capacity and decrease the burden on local contractors. SSDI funding will also be used to improve and develop data collection and analysis systems for MCH data based on the BPA recommendations. //2008//

/2009/

Montana's maternal and child health population continues to depend on the local public health workforce for addressing their health care needs, of which the MCHBG provides significant funding to many of the state's 56 local public health departments. As noted throughout the application, the FCHB continues to review and revise the Blueprint for Maternal and Child Health in Montana that is the foundation for the Bureau's activities related to the performance measures.

The Public Health Home Visiting Business Process Analysis, more commonly referred to as the PHHV Reassessment Process, and the WIC Futures Study Group began meeting in FY 2008 and will continue through 2009. These two work groups are composed of state and local stakeholders and are charged with submitting suggestions and/or recommendations to the Bureau as to how to be more efficient in administering and collecting data related to the PHHV and WIC Programs. The lessons learned by these two groups provide a basis to learn from and incorporate into future Bureau work groups. //2009//

/2010/

The Governor appointed Family Health Advisory Council, working with the Family and Community Health Bureau (FCHB), developed the Report on Maternal Child Health Services in the State of Montana. This report outlines the activities and accomplishments of the FCHB for 2007-2008. Per the Executive Order for the Family Health Advisory Council, this report outlines the Council's six (6) recommendations for maternal and child health services for Montana's children and families for the upcoming biennium. The report provides a concise summary of the Bureau's efforts addressing the national performance measures and its 2009 goals. The report is accessible at: http://www.dphhs.mt.gov/PHSD/family-health/FCHB-index.shtml

The WIC Futures Study Group and Public Health Home Visiting (PHHV) Reassessment Process met throughout 2009 and developed a number of action steps that will be addressed this coming year. The PHHV minutes are shared electronically with the stakeholders and the WIC Futures Study Group's minutes are available at: http://www.dphhs.mt.gov/PHSD/family-health/nutrition-wic/WIC-futures-study-group.shtml

It is anticipated that the new WIC data system, M-SPIRIT, which is anticipated to be implemented in December 2009, will aide in the collection of WIC data as related to the MCH BG performance measures. USDA funding has financed M-SPIRIT. The PPHV

Reassessment Process has outlined data reporting requirements and contractors may use contract funding to purchase software.

The MCH Toll free hotline remains as a partnership with the Children's Health Insurance Plan (CHIP). Citizen initiative I-155 was approved by the voters in November 2008. The 2009 Legislative Session allocated funds to the program, which also changed the name of CHIP to the Healthy Montana Kids Plan effective October 1, 2009.

//2010//

G. Technical Assistance

Technical assistance needs identified to date include:

/2010/

Staffing has remained fairly constant since the creation of the FCHB's Strategic Plan, Blueprint for Maternal and Child Health in Montana. However, as the FCHB moves forward with the 2010 Needs Assessment process and refreshes the Blueprint to be reflective of any emerging health needs of the MCH population, additional staff training on how to develop new state performance measures and subsequent program evaluation objectives have been identified as training needs. Staff capacity would be enhanced and increased by these types of trainings. No trainer for either training need has been identified.

//2010//

V. Budget Narrative

A. Expenditures

Montana depends upon its local partners for provision of MCH services to the population. 42% of the MCHBG is distributed to local county contractors under MCH services contract. Local match continues to be well beyond the reuired level, with local match of about $3.6 million, instead of the approximately $825,000 which would be required under the present contract. Montana does not have enough state general fund to pull down the federal funding, with a total of slightly over $1 million, instead of the $1.9 million needed.

Local match continues to increase, partly due to improved reporting expectations and compliance, and due to the response of locals to the request for accurate reporting which will allow better understanding of true costs of MCH services. For the first time in 2004, we were able to capture and report the program income.

Please see attachment for charts depicting trends.

Form 3 - Federal funding stayed about the same from 2001 through 2004 - federal decreases in 2005 and potentially 2006 will result in a drop in the federal level. The state funding also continues to go down slightly. Efforts to increase funding are anticipated for the 2007 session, depending upon fiscal picture. Local funding has had the most increase, albeit variable.

Form 4 - Children continue to be the primary target of services in the state. Screening programs, including school health services would be included in those costs. Many county health departments continue to assume school health services as part of their responsibilities, often without funding from the school district or reimbursement from insurance coverage's.The increase in infant and pregnant women expenditures may be in part attributed to the program income, much of which is for targeted case management for high risk pregnant women and infants. Variations between budgeted and expended amounts continue to vary by as much as 40% in some categories (pregnant women and others).

Form 5 - Direct expenditures reported by the counties continue to be high. This is in part due to definition and reporting issues. Large variations in expenditures by level of the pyramid continue. While definition issues continue to confound, a large percent of funding continues to support direct health care.

/2007/ Montana continues to experience decreases in MCHBG funding due to federal decreases and population shifts. Montana's block grant allocation has decreased by over $180,000 since 2001. County contracts, accounting for approximately 42% of the overall budget have decreased, as have state level program budgets. Cost allocation, or administrative costs, have increased. Counties have continued to overmatch the MCHBG, providing far more match than is required by contract.

Form 4 - Children's services continue to account for the largest portion of the federal/state/local MCH partnership. Counties commit over $2 million annually to services for children aged 1 - 22. Children with special health care needs have also received more resources from counties over the last year.//2007//

/2008/
Montana's block grant allocation was decreased in FFY 06 by $85,000. For FY 08, the federal funding is estimated to remain the same as for FFY 06 and 07, $2,462,222. The county contracts continue to reflect approximately 42% of the total budget. The cost allocation or administrative costs increased, but are within the 10% threshold. Children's services continue to receive the greatest portion of the federal/state/local MCH partnership. //2008//

/2009/

Montana's block grant allocation was decreased by $38,000 in Fiscal Year 2008, resulting in the decision not to rehire the Child Health Coordinator housed in the CACH Section. Montana was able to maintain 42% of the total block grant allocation being distributed to 53 of the 56 local public health departments. Children's services continue to receive the greatest share of the MCH Partnership. //2009//

/2010/

Montana anticipates that the full amount requested for FY 2010 will be allocated; however, if funding is decreased at the Federal level, the Bureau sections' MCH budgets as well as to the local county health departments will need to be revised. The county health department contract includes language for such an occurrence. As stated elsewhere, all state government agencies are under a 7% vacancy savings rule; therefore, vacant positions will be vacant longer.

The county health departments will continue to receive approximately 42% of the funding in FY 2010 and 30% to children with special health care needs. For FY 10, the cost allocation or administrative costs decreased slightly and is below the 10% threshold.

//2010//

B. Budget

The proposed budget for FFY 2006 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs $829,709
Primary and Preventive Services for Children $ 1,008,269

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs $829,709

Budget includes the CSHS budget of $764,000 plus $65,000 of cunty MCHBG which they report expending on the CSHCN population.

Title V Administrative Costs $224,404

Includes state indirects of $176,633 plus anticipated local of $47,777. Administrative rule allows counties to use up to 10% of their award for administrative costs. The state admin costs are increased by approximately $40,000, due in part to conversion of the BC position for "direct pay" to cost allocation.

Unobligated balance $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $1,085,637

Budget includes public health home visiting general funds ($550,000) and funds to support the voluntary genetics program (apprximately $530,00).

Local MCH Funds $3,598,977

Local contractors continue to overmatch their contracted $1.1 million.

Program Income $791,235

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $8,023,781

Other Federal Funds $18,334,262

/2007/

The proposed budget for FFY 2007 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 955,473

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families. Decreased from last year due to decreased federal funding available.

Children with special health care needs $838,666

Slightly increased from last year due to county efforts.

Title V Administrative Costs $194,083

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $1,440,467

Budget includes public health home visiting general funds ($550,000), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $850,000).

Local MCH Funds $3,165,000

Local contractors continue to overmatch their contracted receipts.

Program Income $743,094

County contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Cotnractor imposes any charges for services" under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $7,810,783

Other Federal Funds $19,458,492

Tables depicting the changes in Montana's Title V funding are attached. //2007//

/2008/

The proposed budget for FFY 2008 as outlined on Form 2 includes the following:

Primary and Preventive Services for Children $ 873,000

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families.

Children with special health care needs $838,666

Title V Administrative Costs $212,658

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $2,173,902

Budget includes public health home visiting general funds ($550,013), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $1,045,000 per 2007 Legislative action).

Local MCH Funds $3,500,746

Local contractors continue to overmatch their contracted receipts.

Program Income $914,508

Program Income shows an increase due to CSHS' clinic billing. Also county contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $9,051,378

Other Federal Funds $19,104,399

//2008//

/2009/

The proposed budget for FFY 2009, as outlined on Form 2, reflects a decrease from the amount received in FFY 2008. Form 2 includes the following:

Primary and Preventive Services for Children: $818,763 ($ 873,000 in 2008)

This budget item includes the budget for the state level Child, Adolescent and Community Health Section and county level MCH anticipated to be spent for infants, children and others, including families. Decreased from last year due to decreased federal funding available.

Children with special health care needs: $823,666 ($838,666 in 2008)

Title V Administrative Costs: $225,325 ($212,658 in 2008)

Includes state indirects and local administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated balance $0 ($0 in 2008)

Montana continues to budget and expend to the level of the annual award.

State MCH Funds $2,352,554 ($2,173,902 in 2008)

Budget includes public health home visiting general funds ($550,013), small amount of general funds to support MCH Administrative activities, and funds to support the voluntary genetics program (increased to approximately $1,045,000 per 2007 Legislative action).

Local MCH Funds $3,510,000 ($3,500,746 in 2008)

Local contractors continue to overmatch their contracted receipts.

Program Income $1,025,000 ($914,508 in 2008)

Program Income shows an increase due to CSHS' clinic billing. Also county contractors are required to establish a sliding fee schedule which "adjust the charges to the income, resources, and family size of each such individual, and publish the fee schedule if the Contractor imposes any charges for services under Section 1 of the MCH Services Task Order for Montana County Contracts.

Federal-State Block Grant Partnership $9,349,776 ($9,051,378 in 2008)

Other Federal Funds $20,268,575 ($19,104,399 in 2008)

//2009//

/2010/

The proposed MCHBG budget for FFY 2010 as outlined on Form 2 reflects a decrease from the amount received in FFY 2009. Form 2 includes the following:

Primary and Preventive Services for Children: $ 809,683 ($818,763 in 2009) This budget

item includes the budget for the state level the Infant, Children, and Maternal Health Section (ICMHS), formerly known as the Child, Adolescent and Community Health Section (CACH) and the county level MCH budget for infants, children and others, including families.

Children with special health care needs: $838,666 ($823,666 in 2008). This total also includes state CSHS budget and the anticipated amount the local health departments will spend on CSHS services.

Title V administrative costs: $219,162 ($225,325 in 2008). This total includes the state indirect amount and the locals' reported administrative costs. Administrative rule allows counties to use up to 10% of their award for administrative costs.

Unobligated Funds: $0

Montana continues to budget and expend to the level of the annual award.

State MCH Funds: $2,135,677 ($2,352,266 in 2008)

The budget includes public health home visiting general funds, which was decreased from the 2008 budget; a small amount of general funds to support MCH Administrative activities; and funds to support the voluntary genetics program, which was increased to approximately $1,054,629 per 2009 Legislative action.

Local MCH Funds: $3,590,998 ($3,510,000 in 2008)

Local contractors continue to overmatch their contracted receipts.

Program Income: $1,114,333 ($1,025,000 in 2008)

Program Income shows an increase due to CSHS' clinic billing.

Federal State Block Grant Partnership: $9,276,146 ($9,349,488 in 2008)
Other Federal Funds: $20,406,359 ($20,268,575 in 2008)

//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.